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ABSTRACT

"Zero to Three" is a single-focus bulletin of the National Center for Infants, Toddlers, and Families providing insight from multiple disciplines on the development of infants, toddlers, and their families. An outgrowth of the Head Start Forum on Infant Mental Health, this issue focuses on infant mental health and implications for Early Head Start programs. The articles are as follows: (1) "A Commitment to Supporting the Mental Health of Our Youngest Children" (Rachel Chazan-Cohen, Judith Jerald, and Deborah Roderick Stark); (2) "Towards a Definition of Infant Mental Health" (Charles H. Zeanah, Jr., and Paula Doyle Zeanah); (3) "A Developmental Psychiatrist Looks at Infant Mental Health Challenges for Early Head Start: Understanding Context and Overcoming Avoidance" (Robert N. Emde); (4) "Fathers as Facilitators of Infant Mental Health: Implications for Early Head Start" (Hiram E. Fitzgerald and Marcel Montanez); (5) "The Sociocultural Context of Infant Mental Health in African American Families" (Suzanne M. Randolph and Sally A. Koblinsky); (6) "Is Mom's Mind on Her Baby? Infant Mental Health in Early Head Start" (JoAnne E. Solchany and Kathryn E. Barnard); (7) "Mothers, Babies, and Depression: Questions and Answers" (Roseanne Clark and Emily Fenichel); (8) "Relationships for Learning: Early Head Start Infant Mental Health in Jackson, Michigan" (Deborah J. Weatherston); (9) "Infant Mental Health at Hope Street Is Everybody's Business" (Cecilia Samartin and others) [in English and Spanish]; and (10) "Organizational Environments that Support Mental Health" (Robert N. Emde, Judith Bertacchi, and Tammy L. Mann). Regular departments of the bulletin list Zero to Three publications, videotapes, and on-line resources, and announcements about Zero to Three staff. (HTH)



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August/September 2001
Volume 22 No. 1

Bulletin of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Infant Mental Health and Early Head Start:

*Lessons for early
childhood programs*

☐ A commitment to supporting
the mental health of our
youngest children

☐ The challenge:
Understanding context,
overcoming avoidance

☐ Reports from Early Head
Start and community-based
programs

☐ Organizational environments
that support mental health

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This issue of *Zero to Three* is an outgrowth of the ambitiously and imaginatively conceived Head Start Forum on Infant Mental Health, held in October 2000. It is also the first product of the Early Head Start Infant Mental Health Initiative, housed at the Early Head Start National Resource Center at ZERO TO THREE, which has been designed to explore issues and address needs raised by participants in the Forum.

The contributors to this issue, who were also presenters at the Forum, offer readers new research-based information about the mental health of very young children and their families; guidelines for practice; and strategies for building the organizational capacity to do this difficult work. The knowledge and wisdom offered here are applicable to all programs serving very young children and their families.

The contributors to this issue write with extraordinary candor. They show us the dedication and sensitivity of front-line practitioners, but also their feelings of inadequacy and helplessness. They acknowledge the difficulty of recognizing psychological suffering in very young children and identify major shortcomings in the service system. Yet with great compassion, authors point the way toward positive change: A gently made observation can acknowledge a parent's pain and make it safe to speak; support from co-workers and supervisors strengthens a practitioner's ability to act effectively; a small program can become a model of reflective practice; a large organization can take deliberate steps toward cultural competence; Federal agencies can pool resources to promote and protect the mental health of our youngest children.

We thank the authors who gave so generously of their time and talent to make their Forum presentations meaningful and useful to the widest possible audience, and to the Head Start Bureau, whose support has made it possible to produce and disseminate this resource.

Emily Fenichel
Editor

P.S. For the first time, we are publishing an article in both English and Spanish (See pp. 59-66). We welcome your feedback.

An invitation to contribute to *Zero to Three*.

The April/May 2002 issue of *Zero to Three* will explore the concept of perinatal mental health. By this we mean the normative developmental issues and crises that arise as adults make their transition to parenthood. This issue will include brief descriptions of how individual practitioners and programs are thinking about and addressing the mental health of expectant and new parents.

We invite readers' answers to one or more of the following questions:

1. How do you provide consistent psychological and physical support to expectant parents from pregnancy through childbirth and the first 6 months of their baby's life?
2. How does your program address the mental health issues and developmental issues unique to the perinatal period?
3. How are diagnostic and treatment services for postpartum depression and related psychiatric diagnoses integrated into your clinical interventions?
4. Write a job description for a perinatal mental health clinician. What training would this person need to be able to understand the spectrum of perinatal mental health promotion, prevention, and treatment?

Please send responses of 750 words or less, with contact information, by email to Linda.Mayes@yale.edu by **December 31, 2001**.

Linda Mayes, M.D. and Neill Epperson, M.D.,
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ZERO TO THREE



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A COMMITMENT TO SUPPORTING THE MENTAL HEALTH OF OUR YOUNGEST CHILDREN

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The time has come for the development of a comprehensive initiative to address the mental health of infants, toddlers and their families. New theoretical, practical and empirical knowledge from the young (but growing) field of infant mental health has taught us that emotional development in the earliest years of life sets the stage for children's exploration and later readiness to learn, and, indeed, is the foundation for all later development. This new knowledge provides all settings that serve infants, toddlers and their families with great opportunity and challenge as they try to modify existing practice. As a nation, we must find ways to support the emotional health of our youngest children and their families through a continuum of comprehensive, individualized, culturally competent services that focus on promotion, prevention and intervention. Attention to the emotional health of infants and their families will not only address the first step for school readiness, but it will also help families be stronger, supportive teachers for their children.

As a step in this process, the Administration on Children, Youth and Families convened an Infant Mental Health Forum in October 2000. The Forum was attended by more than 140 people representing parents; Early Head Start and Migrant Head Start directors, program staff and home visitors; early educators; training and technical assistance

providers; researchers; pediatricians; psychiatrists; psychologists; social workers; federal partners; and private foundation representatives. The purposes of the Forum were to:

- develop a common understanding of the term "infant mental health";
- focus on the role that Early Head Start and Migrant Head Start programs—in collaboration with their community early care and education partners—play in promoting the social and emotional development of infants and their families; and
- identify action steps that should be part of a comprehensive initiative to address infant mental health using Head Start as a leader for the field.

This issue of *Zero to Three* is designed to bring the richness of the Infant Mental Health Forum to a wide infant/family audience. Articles by Forum presenters feature their thinking about infant mental health in the context of Early Head Start, Migrant, child care, and other community-based programs, as well as detailed descriptions of infant mental health practice in Early Head Start programs. In this article, we present:

- major themes and issues of the Forum;
- principles, derived from Forum discussions, that should guide any training, technical assistance, research, demonstration efforts or policy to address infant mental health; and



PHOTO: MARILYN NOLT

- a description of the new Early Head Start Infant Mental Health Initiative, which is designed to enhance the ability of Early Head Start and Migrant programs and their community early care and education partners to support the emotional health of children.

While the concerns, principles, and practice approaches presented and discussed in the Infant Mental Health Forum are, we believe, applicable to all community-based programs serving very young children and their families, it is also true that the Head Start community may be particularly well situated to provide leadership in infant mental health. Head Start has a long history of providing comprehensive early child development services to low-income children, their families, and communities. Since 1965, the program has served nearly 18 million children and their families (Administration on Children, Youth and Families, 1998), providing preschool-aged children with education, nutritious meals, and access to health, mental health and social services that support their early development. Further, the program has influenced the development and direction of a broad range of early child development services across the

nation through its role as a national laboratory. Recognizing the importance of the first three years of life, the Federal government made a commitment in 1994 through the Head Start Reauthorization legislation to expand Head Start to serve younger children. The Department of Health and Human Services developed Early Head Start to provide ser-

at a glance

- Our country must support young children's emotional health through a continuum of comprehensive, individualized, culturally competent services that focus on promotion, prevention, and intervention.
- Principles to guide infant mental health policy, service delivery, training, and research emerged from ACYF's October 2000 Infant Mental Health Forum.
- The new Early Head Start Infant Mental Health Initiative, along with other Federal, state, local and private-sector initiatives, can serve as a national laboratory for community-based IMH strategies.

HEAD START PERFORMANCE STANDARDS RELATED TO MENTAL HEALTH

Head Start embraces a vision of mental wellness. Head Start Performance Standards focus on the effective and timely provision of services to the people (parents and staff) most directly involved in addressing the mental health needs of children.

The objective of the Performance Standards related to child mental health (45 CFR 1304.24) is to build collaborative relationships among children, families, staff, mental health professionals, and the larger community, in order to enhance awareness and understanding of mental wellness and the contribution that mental health information and services can make to the wellness of all children and families.

- Grantee and delegate agencies must work collaboratively with parents by:
 1. soliciting parental information, observations, and concerns about their child's mental health;
 2. sharing staff observations of their child and discussing and anticipating with parents their child's behavior and development, including separation and attachment issues;
 3. discussing and identifying with parents appropriate responses to their child's behaviors;
 4. discussing how to strengthen nurturing, supportive environments and relationships in the home and at the program;
 5. helping parents to better understand mental health issues; and
 6. supporting parents' participation in any needed mental health intervention.
- Grantee and delegate agencies must secure the services of mental health professionals on a schedule of sufficient frequency to enable the timely and effective identification of and intervention in family and staff concerns about a child's mental health; and
- Mental health program services must include a regular schedule of on-site mental health consultation involving the mental health professional, program staff, and parents on how to:
 1. design and implement program practices responsive to the identified behavioral and mental health concerns of an individual child or group of children;
 2. promote children's mental wellness by providing group and individual staff and parent education on

mental health issues;

3. assist in providing special help for children with atypical behavior or development; and
4. utilize other community mental health resources, as needed.

Head Start Performance Standards concerning accessing community services and resources (45 CFR 1304.40 [b]) require grantee and delegate agencies to work collaboratively with all participating parents to identify and continually access, either directly or through referrals, services and resources that are responsive to each family's interests and goals, including education and other appropriate interventions, including opportunities for parents to participate in counseling programs or to receive information on mental health issues that place families at risk, such as substance abuse, child abuse and neglect, and domestic violence.

Performance Standards related to parent involvement in health, nutrition, and mental health education (45 CFR 1304.40[f]) specify that grantee and delegate agencies must ensure that the mental health education program provides, at a minimum:

- a variety of group opportunities for parents and program staff to identify and discuss issues related to child mental health;
- individual opportunities for parents to discuss mental health issues related to their child and family with program staff; and
- the active involvement of parents in planning and implementing any mental health interventions for their children.

Performance Standards (45 CFR 1304.40 [c]) require Early Head Start grantee and delegate agencies serving pregnant women to assist them to access comprehensive prenatal and postpartum care, including mental health interventions and follow-up, including substance abuse prevention and treatment services, as needed.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Head Start Bureau. Head Start program performance standards and other regulations. 45 CFR Parts 1301-1306, 1308, and guidance. Washington, DC: U.S. Department of Health and Human Services.

vices and supports to pregnant women and families with infants and toddlers. Early Head Start extends Head Start's national laboratory role so that research about outcomes, best practices and program models can influence the field, thus enhancing early care and education programs so that infants and toddlers can receive the high-quality care they need and deserve.

Since its inception in 1995, Early Head Start has grown from 68 programs to 693 today, serving more than 55,000

children across the country. Early Head Start puts resources into a constellation of high quality supports and services that will promote healthy child and family development, and backs them with a Federal commitment to training, program Performance Standards, and monitoring for high quality of early education practices, research and evaluation, and services coordination. It enables families and communities to design flexible and responsive programs but requires that, at a minimum, programs provide home visits, child develop-

ment, health and nutrition services for young children and pregnant women, and develop family and community partnerships. Not only does Early Head Start build capacity within its own programs to address the comprehensive needs of the children and families it serves, but the Performance Standards that guide Early Head Start practices require that the programs reach out to community early care and education partners to build a system of support and quality care for all children.

A Dialogue About Infant Mental Health Begins

Concern about supporting the social and emotional well being of children is shared among program directors and staff of Early Head Start, Migrant, and preschool Head Start. While the country in recent years has paid increased attention to the mental health of children, most discussions have focused on the school-age population and issues surrounding treatment rather than the full continuum needed to support children — beginning with promotion and prevention and including intervention (U. S. Department of Health and Human Services, 2001). But teachers and parents in the Head Start community — and in early care and education settings in general — report that they are struggling to understand and address the mental health needs of very young children and their families and lack the knowledge, skills and infrastructure within the community to assess and serve children. In part, they acknowledge, this is because of a lack of specific training for staff on social and emotional development; in part, this is because of the dearth of mental health services in the communities that programs would hope to turn to for guidance, support and services for the infants and their families; in part, this is because of society's denial that infants have mental health needs (See Zeanah, this issue).

At the Infant Mental Health Forum, the mental health provisions included in the Head Start Program Performance Standards (See sidebar, p. 6) guided discussion to address promotion, preventive intervention, and treatment. Discussion also focused on the context for mental health, including age-appropriate developmental sequence, parental factors, relationships between young children and parents in their immediate environment, and the full range of factors that influence the emotional health of very young children and their families. There was a general consensus among presenters and participants about the importance of context — relational, family, community and cultural — both in understanding infant behavior and in designing intervention services. However, all of the speakers returned to the experience of babies and toddlers — including, at times, their suffering — as the imperative for providing prevention and intervention services.

Throughout the discussion, there was general agreement that early care and education alone cannot provide the range of services needed to support emotional development of infants, toddlers and their families. Similarly, there was

agreement that a small dose of mental health services cannot be a panacea for those very young children and their families who are most challenged due to environmental or biological characteristics. Only a continuum of services and supports, offered by qualified providers, can meet the individual needs of infants and their families over an extended period of time.

Forum discussions led to the development of:

- a rationale for attending to the emotional well being of infants, toddlers and their families;
- principles that should guide any research, training, program and policy directives;
- a list of issues that warrant further attention and deliberation; and
- suggested action steps, many of which will be addressed through the Early Head Start Infant Mental Health Initiative.

A Rationale for Attending to the Emotional Well Being of Infants, Toddlers and Their Families

Participants at the Infant Mental Health Forum expressed strong concern about the ability of early care and education settings — including Early Head Start, Migrant Head Start, and early care and education programs — to respond to the social and emotional needs of infants and their families. Given the interrelationship between the multiple domains of development and strong research and practice evidence for the importance of social and emotional development in the equation, participants urged immediate action to develop a purposeful multidisciplinary approach for attending to the emotional well being of infants and their families.

A secure and responsive relationship between the infant or toddler and his or her primary caregivers is the foundation of mental health in the earliest years and the context in which healthy social and emotional development continues to flourish. Early care and education programs have unique opportunities to promote infant mental health. From the way teachers interact with infants during feeding and diapering to the way they engage parents in the care of their child, early care and education programs are continuously building and nurturing relationships which support the social and emotional development of infants and their primary caregivers.

For some very young children and families served by community programs, factors such as maternal depression, domestic violence, poverty, homelessness, and a lack of supports for the family pose challenges to mental health promotion. Biological factors affecting the child — such as prematurity, low birth weight, disability and difficulties in sensory processing and regulation — may also present obstacles to healthy emotional development. The cumulative impact of multiple risk factors poses a particularly potent threat to infants' and families' mental health. The strong relationships that staff in Early Head Start, Migrant, child care, and

other community programs develop with families provide staff with a unique vantage point from which to observe mental health concerns or the emergence of problems. Strong relationships also provide a context of mutual trust and respect between families and staff that makes it easier to offer, provide, or coordinate needed – but often stigmatized – mental health services. Thus it is important for program staff to: understand the factors that influence infant mental health; know how their work with families can best support emotional development and address mental health concerns; and establish and maintain relationships with other community providers who are able to offer more intensive and specialized services for the child and family.

Responding to the comprehensive social and emotional needs of the infant and family is more easily said than done. The field of infant mental health is relatively new, and there are few people trained in relationship-based mental health promotion, prevention and intervention practices. There are even fewer people who are trained to understand how culture can be used as a resource in working with families. With our increasingly diverse society, it is ever important that all interactions with families are informed by and honor the infant's home culture. Collaboration across agencies is still a challenge, with some communities succeeding in forging partnerships and blending funds, and others not even trying because of the overwhelming complexity of multiple systems — each with its own philosophy, history, professional backing, and funding streams. General funding that can be used to provide mental health services is limited and complicated by federal and state restrictions. In addition, disincentives in many managed health care plans can make it difficult for families to secure any mental health ser-

vices, but especially resources for promotion and prevention. Finally, there is little public understanding of the critical importance of the early parent-child relationship and its influence on child development.

The work that must be done to address the mental health needs of our country's youngest children and their families transcends the expertise or capacity of any one professional discipline, organization, or private or public agency. It includes:

- increasing public awareness about infant mental health and reducing the stigma associated with mental health services;
- promoting public policy that acknowledges the importance of early social and emotional development by providing direction and adequate funding to build collaborative systems of care in communities;
- stimulating cross-disciplinary collaboration;
- developing appropriate tools and measures for assessing young children's mental health and planning meaningful mental health promotion, prevention, and treatment;
- developing evidence-based training and professional development resources and opportunities, including reflective supervision; and
- evaluating practice in order to improve effectiveness with children and families and assess long-term impacts in the community of an increased focus on infant mental health.

Building a system of care in communities to support the emotional well being of infants and their families requires a multidisciplinary approach to establish and maintain an available continuum of mental health services. Because of its historic and continuing role as a national laboratory, Head Start is well positioned to lead the way in forming the partnerships, influencing training and practice, and conducting research that will ultimately enable a comprehensive approach to the emotional health of infants and their families to emerge.

Guiding Principles

Infant Mental Health Forum participants recognize that a comprehensive approach to the emotional health of infants and their families must be guided by a set of principles that influence policy, programming, service delivery, materials development, training, technical assistance, research and funding. Not unlike the principles that undergird the Early Head Start program and other health and social initiatives of the late 20th and early 21st century, the principles outlined below convey respect for the individual, appreciation of strengths, and the need for continuous, stable and accessible relationships and supports. Further, the guiding principles define the ways in which the systems — early care and education, early intervention, health, and higher education — can work individually and collectively to create an environment that honors the relationships necessary for promoting the emotional health of infants and their families.



PHOTO: JANET BROWN MCCracken

The relationships that infants, toddlers and families need

All pregnant mothers, their partners and new parents need to be part of relationships that support their emotional well being and prepare them for the joys and challenges of parenthood. And all infants need to be part of stable, caring, loving relationships with their parents and other primary caregivers so that their cues can be understood and addressed in ways that support and nurture their emotional development. Infants, toddlers, and the adults who care for them — parents, non-parental caregivers, and other community providers — need relationships that are:

- **Individualized:** Attention must be given to the individual needs of the infant and the parents. Responsive caregiving of the infant that acknowledges and addresses the infant's needs and behavioral temperament will convey the respect and security essential for early emotional development. Responsivity to parents' individual circumstances and life histories can enable parents to more comfortably engage in a beneficial relationship with their infant.
- **Strengths based:** Early relationships must emphasize the strengths and resources of each participant. Everyone has strengths, even the newborn. Helping parents understand the strengths of their infant, and the strengths that they bring to their caregiving, builds confidence within parents and supports positive interactions between parents and their babies. A strengths-based approach does not ignore the significant challenges many families confront. Rather, this approach suggests that by understanding the profile of strengths and weaknesses of the child and family, programs are better able to provide individualized services that focus on promotion of emotional health, and prevention and intervention when risks and problems are identified.
- **Continuous and stable:** For the infant, continuous and stable caregiving builds confidence that their needs will be met. Especially in the earliest years, it is important for infants who are cared for out of the home to have a long-term relationship with a primary caregiver. For the parent, knowing that there are consistent people they can turn to — the child's caregiver, a home visitor, extended family, network of formal and informal support — is equally important. Not only do specific child/caregiver and parent/staff relationships need to be continuous and stable, but the supports and services provided need to be continuous and stable as well. There is no vaccination to guarantee healthy emotional development or a way to restore emotional wellness overnight. The more complex the needs of the family and young child, the more intense and extensive the services required. While early care and education programs can promote emotional development through best practices that focus on relationships, it is unrealistic to expect that these programs will ever be equipped to provide the

more intensive services required by infants and families with complex mental health needs. Only a well-coordinated continuum of community-based services and supports is likely to be able to offer families the specific help they need at any particular point in time.

- **Accessible:** Relationships need to be accessible and responsive to when and how the infant and parent need attention and support. To achieve this for the infant, parents need to understand the child's rhythm, being mindful of the cues the infant sends when seeking attention as well as those cues the infant sends when he or she is over-stimulated. Parents and caregivers also need to be participants in supportive relationships. When program and administrative staff are available and able to meet parents' and caregivers' needs, families and front-line providers are likely to be more able to engage in responsive relationships with babies and toddlers.

Systems that support early relationships

The early relationships that provide the foundation for future social, emotional and cognitive development must be supported by systems that are:

- **Child focused and family centered:** The services, training, policy, funding and research of systems need to support the well being of the infant and the active involvement of all family members — mothers as well as fathers and father figures — to achieve optimal infant development. A true family-centered system includes family members, caregivers, and administrators as equal partners on a cohesive, responsive, respectful, interdependent team that is focused on meeting both the child's and family's needs in order to support the emotional health of the infant and family.
- **Culturally responsive:** Systems need to recognize the importance of understanding the values, beliefs, and practices of diverse cultures. They must integrate diversity into the policies, practices and products of organizations so that interactions with individual children and their families can be mindful of and honor their home culture.
- **Community based:** Systems need to be community based so that they can offer more targeted services and supports that reflect the particular needs, strengths, resources and cultures of the community. Having staff who are of the community further enriches the appropriateness of interactions that support infants and their families.
- **Comprehensive, coordinated and integrated:** In addition to being based in the community, systems need to offer comprehensive services and supports to infants and their families that reflect the continuum of care needed — from promotion, to prevention and treatment. Coordination among agencies ensures that planning and implementation of services are undertaken in partnership with staff and agencies from different

systems that together make a formal commitment to providing the services and supports the infant and family need. It also ensures that resources and opportunities — including training opportunities — are shared.

- **Committed to continuous improvement and reflective supervision:** At every level, systems must be committed to creating an environment that values and practices continuous improvement. Reflective supervision offers staff a safe, nurturing environment in which they can regularly reflect on their experiences and gain new knowledge and perspectives that will help them better approach their work with infants and families (Mann, 1997 and this issue).

Issues for Further Deliberation

Forum presenters and participants raised a number of issues that warrant further attention and deliberation as steps are taken to address infant mental health. Thoughtful discussion of these issues will help to define the work and the resources needed for carrying it out.

- **Nomenclature:** The term "infant mental health" has advantages and disadvantages. We need a common language to describe all aspects of early emotional development that can be understood by families, early childhood service providers, and clinicians.
- **Skills and experiences of providers:** Significant discussion is still needed to gain clarity about the skills and experiences required to provide infant mental health services across the continuum of promotion, prevention, and intervention. As part of this discussion, it is important to define the roles and expectations for the various providers and systems that need to work together to provide a full complement of services, depending on the needs of the individual infant and family.
- **Cultural competence:** We are a long way from understanding how families of different cultural backgrounds perceive infant mental health and the most appropriate mechanisms for addressing the issues of the infant while respecting the culture of the family. The complexity involved in establishing culturally competent caregivers, programs, and service systems underscores the importance of developing policies and practices that honor the beliefs, values and practices of all families with infants and toddlers.
- **Training:** Current training and professional development systems are inadequate to educate caregivers about relationship-based mental health promotion, prevention and intervention practices.
- **Reflective supervision:** Increased attention to supervision and training go hand in hand. It is through reflective supervision that many current front-line staff within Head Start and early care and education programs will receive the support and training they need to understand overall infant development, normal and abnormal emotional development, and when and how to respond

to particular behaviors. Further discussion is needed about how best to support programs and supervisors so that they have the understanding and the resources to effectively carry out reflective supervision.

- **Emotional well being of staff:** In order to promote the emotional development of infants, toddlers and families, attention must be paid to the emotional well being of those who work with them. It is nearly impossible for staff to model and support the relationships infants and their parents need if they are not physically and emotionally healthy themselves. This issue was raised repeatedly in discussions, and warrants a fuller dialogue.
- **Screening and assessment:** Few program-friendly tools accurately screen and assess infants' and toddlers' emotional development. Much more work is needed to develop and test functional screening and assessment tools. As such tools are designed, attention needs to be given to ensuring that they are program friendly, culturally appropriate, use observation, involve parents, and measure the continuum of need for mental health supports and services.
- **Infants and toddlers with special needs:** Further discussion is required to clearly identify the special issues and appropriate responses to the mental health needs of this population.
- **Infants and toddlers in the child welfare system:** Further consideration needs to be given to these children, who are likely to suffer a double disadvantage — first, from living within the foster care system, which is highly unpredictable and unstable, and second, from not receiving the mental health services they need during



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this vulnerable period of their development.

- **Financing:** Continued discussion is needed with the school systems, community mental health systems, managed care companies, state Medicaid agencies, State Children's Health Insurance Programs (SCHIP), the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration), and others to find ways to increase access and coordination so that infants and their families can receive the services and supports they need early on, hopefully reducing the need for extensive long-term therapeutic interventions.
- **Evidence-based interventions:** Discussion and research are needed to better understand what interventions work for whom, how, and why. As this research moves forward, it will be important to consider how effectiveness differs depending on a number of factors, including but not limited to age of the child, family characteristics, problem or risk factor, community resources, and culture.

Taking Action

The Federal Context

A theme that emerged from the Forum was the need for broad community action in order to identify and serve the emotional needs of our youngest children and their families. There was consensus that in order to truly support the emotional health of infants and their families, efforts need to be taken to build knowledge and capacity throughout the field of early care and education as well as related fields of health, mental health, and social services. In fact, the Federal government, state governments, and private entities have sponsored many efforts aimed at learning how best to support the emotional health of families with young children. While we cannot present a comprehensive review, the following are a sample of current activities across agencies of the Federal government.

- **The Office of Juvenile Justice and Delinquency Prevention**, located in the U. S. Department of Justice, funded Safe Start in 1999 in order to demonstrate how to prevent and reduce the impact of family and community violence on young children (primarily from birth to 6 years of age). The goal is to create a comprehensive service delivery system by helping communities to expand existing partnerships among service providers in the fields of early childhood education, health, mental health, and family support. They also aim to strengthen domestic violence, substance abuse prevention and treatment, crisis intervention, child welfare, law enforcement, and court and legal services.
- **The Office of Special Education Programs (OSEP)**, located in the Office of Special Education and Rehabilitation Services (OSERS), within the U. S. Department of Education, is funding several efforts focused on the emotional needs of young children and

their families through Part D of the Individuals with Disabilities Education Act. New initiatives for FY 2001 include a Research and Training Center to conduct a program of research to improve interventions and service delivery systems associated with the healthy mental development of infants, toddlers, and preschool children with, or at risk of developmental disabilities. A Center for Evidence Based Practice will be awarded in September 2001 to identify effective practices and improve services for young children with, or at risk for, behavioral problems and their families. This center will focus on collaboration between education, early care and intervention, medical, and mental health providers that identify and serve these children and their families. OSEP's most recent announcement for research projects included a priority focus on early childhood mental health; three projects will be awarded in September 2001. In response to OSEP's 2001 priority for directed model demonstration projects, demonstration projects will be funded to develop exemplary family-focused community mental health models for children under age 6. In addition, OSEP funds ongoing demonstration, outreach and research projects to address and evaluate the social/emotional/ and mental development of children, ages birth through 21 and their families.

- **The Substance Abuse and Mental Health Services Administration**, in the U. S. Department of Health and Human Services, in collaboration with the **Casey Family Programs** funded the first Starting Early/Starting Smart (SESS) demonstration projects in 1997. The goal of SESS is to test the effectiveness of integrating behavioral health intervention services (substance abuse prevention, treatment, and mental health) in primary health and early childhood settings for children from birth to age 7 and their families at risk for substance abuse and mental health disorders. The most recent announcement (Summer 2001) specifically encouraged Early Head Start programs to apply for funding.
- **The Administration on Children Youth and Families (ACYF)** in the U. S. Department of Health and Human Services is engaged in several efforts designed to develop capacity in order to better support the social and emotional development of children birth to age 5. In collaboration with **National Institute of Mental Health (NIMH)**, ACYF awarded five research grants in 1997 as the core component of a new young children's mental health research initiative designed to develop and test applications of theory-based research or state-of-the-art techniques for the prevention, identification and/or treatment of children's mental health disorders within a Head Start context.
- Following the October, 2000 Infant Mental Health Forum, ACYF's **Child Care Bureau** convened a

National Leadership Forum with child care, health, and mental health professionals on March 6, 2001. The purpose of the one-day Forum was to bring together leaders in the field to focus on ways of creating and strengthening partnerships between child care and mental health to meet the needs of young children and their families. A report based on the themes of the Forum is in preparation.

- In Summer, 2001, ACYF's **Head Start Bureau** and the **Child Care Bureau** announced a joint funding opportunity for a national resource center to help Head Start and Child Care programs identify and implement practices with demonstrated effectiveness in promoting children's social and emotional competence. The center will develop and demonstrate approaches that will complement and extend the efforts of existing Head Start and Child Care training and technical assistance providers to improve social and emotional outcomes for young children.

The Early Head Start Infant Mental Health Initiative

Within the larger context of Federally funded activities related to young children's mental health, Early Head Start is taking a number of integrated action steps designed to build on learnings generated from the Forum on Infant Mental Health. The Head Start Bureau is supporting the Early Head Start National Resource Center (EHS NRC) at ZERO TO THREE to engage in a number of follow-up activities critical to maintained sustained focus on this important issue.

The overall approach to implementing follow-up activities will reflect principles that guided the planning and implementation of the Forum. Specifically, the EHS NRC will engage a broad spectrum of multidisciplinary experts, program staff, training and technical assistance providers, researchers and parents in the development and dissemination of the follow-up activities. The EHS NRC will work to make certain that knowledge generated from related Federal, state, and private-sector initiatives inform their work as follow-up activities are carried out. This issue of *Zero to Three* represents one important step in disseminating the presentations and discussion of the Forum, and beginning dialogue with the larger infant/family community. Additional activities include consensus building, information gathering, and training.

- **Consensus building:** A 22-member Task Force will be established to examine, at a more in-depth level, questions that arose during the Forum around the "meaning" of infant mental health from a promotion, prevention, and treatment perspective. This Task Force will also identify skills and competencies required of staff who work at various points of this service continuum.
- **Information-gathering activities:** Concurrent with activities of the Task Force, the EHS NRC will conduct three information-gathering activities that will

significantly influence the work of the Task Force and enhance understanding of issues that must be considered in planning and implementing infant mental health services. Information gathering will include targeted discussion groups aimed at understanding the impact of culture on the understanding of the meaning of infant mental health. In addition, the EHS NRC will convene state Forums that will replicate select aspects of the October 2000 Forum, extending the experience to engage state leaders, service providers, and parents in substantive discussions around developing and implementing comprehensive systems of care. Finally, through investigative research activities, the EHS NRC will identify state and local systems-of-care models that might serve as templates for communities that are interested in developing coordinated systems of care for meeting the mental health needs of very young children.

- **Training:** Building on the understandings generated by the Task Force, the EHS NRC will develop an intensive training experience for EHS and Migrant programs and EHS' broader support network, aimed at enhancing their capacity to positively impact the social and emotional well being of infants and toddlers in the context of their relationships with parents. The training approach will acknowledge the importance of training teams and of offering follow-up consultation and support.

In conclusion

New theoretical, practical and empirical knowledge about emotional development in the earliest years of life – and about its importance for all later development – awaits translation into practice in all settings that serve infants, toddlers, and their families. The task of translation involves using principles that convey respect for the individual, appreciation of strengths, and the importance of continuous, stable, and accessible relationships and supports to guide policy, programming, service delivery, materials development, training, technical assistance, research, and funding. Much good work is underway, and more will be undertaken through Federal, state, local and private-sector initiatives. Our challenge as a nation is to create and sustain a full continuum of comprehensive, individualized culturally competent mental health services—to make, and then to honor a commitment to supporting the healthy emotional development of our youngest children. ♦

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TOWARDS A DEFINITION OF INFANT MENTAL HEALTH

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This article is excerpted from the keynote address at the October 2000 Head Start Infant Mental Health Forum.

As a field of inquiry and practice, infant mental health has grown dramatically in the past 25 years, from its origins as a novel extension of psychoanalytic psychotherapy to young children and families, to a broad-based, multidisciplinary, and international effort to enhance the social and emotional well being of young children. As the knowledge base and clinical applications of infant mental health have expanded, there has been increasing interest in the field across a broad range of disciplines. The short- and long-term ramifications of ensuring the physical, social and emotional health and well being of our youngest children are drawing the urgent attention of researchers and clinicians across diverse fields. Major initiatives in infant mental health in a number of states reflect growing awareness and commitment among policy makers.

Despite the growth of infant mental health research, practice, and systems development, a commonly accepted definition of the term "infant mental health" itself remains a work in progress. Many people find themselves bemused by or even averse to the term "infant mental health." It is provocative to juxtapose the terms "infant," with its associations of

innocence, beginnings, and hope for a better future, and "mental health," with its associations of maladjustment, stigma, and major mental illness. There is also the question of how to delineate core and specialized knowledge in a field that is clearly multidisciplinary. Finally, it is important to clarify how infant mental health is similar to and distinct from other closely related multidisciplinary fields, such as early intervention and developmental psychopathology.

In this essay we will propose a definition of infant mental health as a characteristic of infants, and as a field of inquiry and practice. To place this definition in context, we will review of the concerns of infant mental health, attempting to highlight those that are unique or to emphasize the unique aspects of concerns shared by other fields.

Concerns of Infant Mental Health

Many professional disciplines have made important contributions to infant mental health, and others clearly have important stakes in the knowledge base. Those disciplines involved in assessing and treating young children, in both mental health and health care settings, are core disciplines in infant mental health. Other disciplines have an active role in various aspects of infant mental health, including child

and adult mental health professionals, pediatric and primary care, education and early intervention, as well as child welfare and legislative and policy planning. Each discipline has a unique perspective through which it perceives infants and their development, although there are many overlapping roles and shared interests in components of the knowledge base (Zeanah, Larrieu & Zeanah, 2000).

Infant mental health clinicians work to enhance the development of very young children and to alleviate their suffering. This work is informed by an appreciation and understanding of several key concepts, including:

- the importance of multiple interrelated **contexts** within which infants develop;
- the process and content of infant **development**;
- **risk and protective factors** as they impact developmental trajectories;
- infant **psychopathology**; and
- **social competence** and **resilience**.

This conceptual framework undergirds the work of infant mental health **assessment**, **treatment**, and **prevention** as it occurs in both mental health and health care settings. It also describes a knowledge base that is useful to a broad range of professionals who can have an active role in various aspects of infant mental health.

Context

The importance of context for infant development is well established. In fact, the inclusion of context in studies of development has been asserted to be the most important research advance in developmental psychology the latter part of the 20th century (Sameroff, 1992). Appreciating the complexities and importance of context has enhanced our understanding of infant development and our ability to predict developmental trajectories (Sameroff & Fiese, 2000).

Intrinsic characteristics that contribute to context may derive from individual differences in genetic endowment, as well as from non-inherited neurobiological differences. Although individual differences in infant characteristics may be identified readily, there is generally little predictive power when infant characteristics are considered alone. For example, studies of preterm infants, many of whom experienced significant perinatal biological insults, have shown repeatedly that the best predictors of outcome are family rather than infant characteristics. In fact, social class of the infant's family is the single best predictor of outcome in these children (Sameroff, 1997). When considered in their relationship context, however, infant characteristics are much more predictive of later emerging behavior problems (Sanson, Oberklaid, Pedlow & Prior, 1991; Mangelsdorf et al., 1990).

Infant-caregiver relationships are the most important experience-near context for infant development. A considerable body of research has documented the importance of qualitative features of the infant-caregiver relationship and infant development. Positive qualities in infant-parent relationships have been linked to more optimal social, emo-

tional and cognitive development (see Crockenberg & Leerkes, 2000; Lyons-Ruth & Zeanah, 1993; Zeanah, Boris & Larrieu, 1997).

Infant-parent relationships moderate intrinsic risk factors in infants (Ramey et al., 1992; McCarton et al., 1997). That is, infants with biological difficulties such as the complications of prematurity have better outcomes when their caregiving environments are supportive and more problematic outcomes when their caregiving environments are less supportive.

Infant-parent relationships also are the conduit through which infants experience environmental risk factors. That is, infants experience risk factors such as poverty, maternal mental illness, and partner violence primarily through their effects on infant-parent relationships. Through their specific relationship experiences, infants are affected by the risk factors that characterize their caregiving environments.

Finally, a significant amount of relationship variability has been noted in the expression of psychopathology in early childhood (Zeanah, Boris & Scheeringa, 1997). Thus, just as infants may construct different types of relationships with different caregivers (Steele, Steele & Fonagy, 1996; Sues, Grossman & Sroufe, 1992), they also may express symptoms in the context of one relationship but not another (Hossain et al., 1994; Zeanah, Boris, Bakshi & Lieberman, 2000).

For all of these reasons, infant mental health has been dominated by a relational approach. This means that infants are best understood, assessed and treated in the context of their primary caregiving relationships. Or as Sroufe (1989) put it, "most problems in the early years, while often manifest poignantly in child behavior, are best conceptualized as relationship problems" (p. 70).

Beyond the dyad, we must consider infant development in the context of the entire family. Not only is infant development related to characteristics of the family considered as a "whole" (Minuchin, 1988), but also there are nontrivial effects from the infant's individualized relationships with various family members (Crockenberg, Lyons-Ruth & Dickstein, 1993). Sibling influences on infant development are not well studied, but they are potentially important. Considerable evidence implicates the parents' marital rela-

at a glance

- Infant mental health may be defined as the state of emotional and social competence in young children who are developing appropriately within the interrelated contexts of biology, relationships, and culture.
- The field of infant mental health may be defined as multidisciplinary approaches to enhancing the social and emotional competence of infants in their biological, relationship, and cultural contexts.
- Infant-caregiver relationships are the primary focus of infant mental health assessment and intervention efforts.

relationship as one of the most important influences on child development (Cummings, 1998). In fact, conflict between parents is a more potent risk factor for young children than divorce itself (Kelly, 2000). That is, young children from low conflict divorced parents appear to fare better than young children from high conflict married parents.

The complexity of family processes challenges our understanding of them. An infant has a relationship with each member of his family, and each of these relationships is influenced by other relationships within the family. For example, a baby has a unique relationship with her mother, her father, and each of her siblings. Moreover, her relationship with her father is influenced by the relationship that father and mother have with another sibling. The numbers of dyadic (one-to-one) relationships within families increases dramatically with increasing numbers of children. In a family with two parents and one child, there are only three one-to-one relationships to consider, but a family with two parents and three children involves 10 dyadic relationships (Emde, 1991). These levels of complexity are rarely approached in research or even in our clinical conceptualizations.

In addition to here-and-now relationships in the immediate family, there are important intergenerational influences upon infant development. These have been demonstrated empirically in various studies of infant-parent attachment.

One of the clearest demonstrations of intergenerational influences was provided by Benoit & Parker (1994), who found significant agreement between mothers' and infants' patterns of attachment, between mothers' patterns of attachment and those of their own mothers' attachment patterns, and between the attachment patterns of grandmothers and their grandchildren.

The cultural context of infant development includes the cultural group's beliefs about parenting and explanations and interpretations of infant behavior (Garcia-Coll & Meyer, 1993; Lewis, 2000). These beliefs include sometimes subtle cultural assumptions about the processes that facilitate infant development, the causes and amelioration of psychopathology, the roles and relevance of parenting, and many other concerns central to infant mental health. Cultures typically develop adaptively in response to larger environmental characteristics, and variabilities in cultural belief systems often can be understood in those contexts. In recent decades, however, increasing technological advances have thrust different cultures together with increasing rapidity and led to intense cultural clashes, efforts at cultural co-existence, and pressures for cultural integration in "the global village." These factors have significant implications for infant devel-

opment, as noted recently by Lewis (2000), who pointed out that technology itself has become a substantive cultural influence for large numbers of infants worldwide.

Infant Development: Process and Content

From an infant mental health perspective, development itself is a context within which infants must be appreciated. Sameroff (Sameroff & Chandler, 1975; Sameroff & Fiese, 2000) has integrated context into the process by which infant development proceeds over time. His transactional model has dominated thinking about infant development for over 25 years. In this model, transactions between the baby and the caregiving environment over time imply reciprocal and bi-directional effects, modifying not only the infant's characteristics and experiences but also gene-environment interactions. The most important discoveries of the first half of the 21st century promise to include detailing the processes of gene-environment interactions over time and their effects on individual development (see Reiss & Neiderhiser, 2000).

In addition to understanding the process of development described by the transactional model, infant mental health professionals and those in related fields need to understand the details of infant development.

Unfortunately, texts on infant devel-

opmental often still describe cognitive, language, social, and emotional development as if they were distinct domains, but the interdependence of these domains is increasingly recognized.

Most commonly, developmental milestones for infancy are conceptualized in terms of developmental epoch, within which change occurs incrementally. These epochs are separated by periods of qualitative change and developmental reorganization occurring at 2-3 months, 7-9 months and 18-20 months of age. The 2-3 month reorganization heralds the beginnings of social responsiveness, the 7-9 month reorganization introduces focused attachment and intersubjectivity, and the 18-20 month reorganization marks the beginning of the verbal and symbolic relatedness. These epochs form the basis for appreciating normative developmental trajectories and their deviations; they provide a framework for understanding both an infant's adjustment at a given moment in time, and more importantly, the nature of the infant's individual developmental trajectory.

Risk and Protective Factors

Certain factors are known to increase or decrease the risks of developmental disruptions and psychopathology. Risk factors are characteristics that increase risk status of an individ-

Family processes are extremely complex. In addition to here-and-now relationships in the immediate family, there are important intergenerational influences upon infant development.

ual or group. Thus infants born preterm, infants of depressed mothers, and infants raised in institutions are considered to be "at risk" of developmental or mental health problems. It is important to remember, however, that risk factors are neither randomly distributed nor unrelated to one another. Complexly interacting risk factors within groups are the rule rather than the exception.

There is a lack of specificity between risks and outcomes. The term **plurifinality** is used when a single risk factor, such as maternal depression, increases risk for a variety of infant outcomes, including insecure attachment (Lyons-Ruth, Connell, Zoll & Stahl, 1987; Shaw & Vondra, 1993), language and cognitive problems (Murray, 1992), and social interactive problems (Weinberger & Tronick, 1997).

Equifinality is the term used when a variety of risk factors increase the risk for a single outcome. For example, maternal depression (Murray, 1992; Shaw, Keenan & Vondra, 1994), parental conflict (Holden & Ritchie, 1991; Shaw, Vondra, Hommerding, Keenan & Dunn, 1994), insecure attachment (Erickson, Sroufe & Egeland, 1985; Lyons-Ruth, Alpern & Repacholi, 1993), maltreatment (Reems, 1999), and perceived difficult temperament (Sanson et al., 1991) are all predictors of aggressive behavior in toddlers. Although considerable knowledge has developed about risk **factors**, much less is clear about risk **processes** — that is, the mechanisms through which risk factors operate to produce poor outcomes (Rutter, 2000).

There is substantial evidence that risks are additive (Beckwith, 2000), with increasing numbers of risk factors associated with increasing vulnerability (Sameroff, Seifer, Baldwin & Baldwin, 1993). In a number of studies, for a number of outcomes, sheer numbers of risk factors are more predictive of maladaptation than any specific risk factor combination (Sameroff & Fiese, 2000; Shaw & Vondra, 1993).

Protective factors may directly reduce the effects of risk, enhance competence, or immunize the individual against adversity (Garmezy, Masten & Tellegen, 1984). Further, protective processes may operate simultaneously or successively even within the same individual in the face of different challenges and at different points in development (Werner, 2000).

A central concern, for infant mental health is the balance between risk and protective factors and their mutual effects on one another. In the first few years of life, environmental risk and protective factors seem to matter more than intrinsic infant risk and protective factors. In the Rochester Longitudinal Study, for example, highly competent infants in high-risk environments fared worse in terms of competence at age 4 years than did less competent infants in low-risk environments (Sameroff, Bartko, Baldwin, Baldwin & Seifer, 1998). Focusing on strengths, and actively working to support, enhance, and promote caregiver and family strengths are formative principles and traditions of infant mental health practice, well supported by research (Knitzer, 2000; McDonough & Zeanah, 1989; Zeanah, 1998).

Psychopathology

Infant mental health is concerned with risk factors that relate to subsequently emerging psychopathology, as well as with already existing psychopathology — that is, serious psychiatric disorders that cause suffering and developmental compromises (Lyons-Ruth, Zeanah & Benoit, 1996; Zeanah, Boris & Scheeringa, 1997).

One major approach to studying infant psychopathology has been developmental psychopathology, a field of research and practice concerned identifying developmental trajectories, and those risk and protective factors that increase or decrease the possibility of certain developmental outcomes. This approach has a number of important advantages for the study of infant psychopathology. For example, since disorders are not often well-differentiated in infancy, this approach allows the study of children with developmental delays or deviance even before a disorder has emerged; findings from such studies are helpful in designing preventive interventions. Furthermore, complex multivariate statistical modeling, a tool used in research in this field, makes it possible to consider multiple risks, protective factors and outcomes simultaneously. Finally, developmental psychopathology's focus on process over time is likely to yield a richer understanding of how specific disorders emerge and can be identified at early stages than an examination of signs and symptoms as they occur in children of a particular age.

To understand and assist an individual child, however, it is more important to understand the child's development and functioning than to catalog the risk factors that may be influencing that child's developmental course. Clinicians must consider whether the distress or maladaptive behavior of a given child at a given moment constitutes a disorder that requires intervention. This introduces the second approach to psychopathology in infancy — that is, considering at least some infant problem behaviors as potential signs and symptoms of psychiatric disorders. The example of posttraumatic stress disorder illustrates this approach.

It is well-known that many adults and older children who have been severely traumatized develop a classic triad of symptomatology, including re-experiencing the trauma, avoiding reminders of the trauma and numbing of responsiveness, and signs of hyperarousal. A series of studies of young children has demonstrated that these same symptoms are apparent in children less than 48 months of age, although their manifestations are different than in older children and adults because of obvious developmental differences (Scheeringa et al., 1995; Scheeringa & Zeanah, 1995; Scheeringa et al., 2001). These studies also have demonstrated that both reports from the caregiver and observations by the clinician are useful in establishing the presence of symptoms in the child. Moreover, the single most potent predictor of severity of symptoms of posttraumatic stress in young children is whether or not the caregiver was threatened in the traumatic event (Scheeringa & Zeanah, 1995). These findings underscore both general similarities in types of symptoms



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apparent between young children and adults and also developmental and contextual differences in the expression of those symptoms. In particular, they highlight the centrality of the infant-caregiver relationship for mediating the effects of extreme environmental stressors on infant development.

Psychopathology is often characterized by the inability to change and adapt, but infants are constantly changing. This means that infant problems must be distinguished from the often-large range of normal variations in behavior and from transient perturbations in development. One way to deal with this challenge is to recognize that psychopathology and maladaptation may not produce static symptomatology; instead, the infant or toddler may exhibit different kinds of problems at different points in development.

Competence

Researchers and clinicians are increasingly concerned with promoting health – that is, enhancing the quality of individuals' experience of life. With respect to young children, practitioners and program developers are looking for ways to encourage social competence – that is, the ability to adapt successfully to differing social environmental demands. Because competence is an ongoing adaptive capacity, competent behavior may look different at different points in development as a child encounters different situations and stressors. A focus on competence also reminds us that symptoms alone do not constitute a disorder; it is the child's ability to function in relationships and to make continuing developmental progress that must concern us.

Resilience — a special form of competence receiving increasing attention — is a term used to characterize infants and young children who achieve positive outcomes despite high-risk status, maintain competent functioning despite stressful life circumstances, and recover from traumatic events and experiences (Wright & Masten, 1997). Increasingly, it has become clear that resilience, like competence, is both a relative construct and one that changes over time and con-

text. Further, rather than a broad overarching construct, resilience may be specific to certain processes, so that individuals who are resilient to some stressors may not be resilient to others (Rutter, 2000).

A relationship with a caregiver who is available and responsive to helping the child navigate the demands of development over time is likely to be the most important factor influencing a young child's ability to achieve positive outcomes, maintain competent functioning under stress, and recover from traumatic experiences. Longitudinal research suggests that young children who are physically attractive and temperamentally appealing are most likely to elicit support and positive responses from adults (Werner, 2000) – an important consideration for clinicians, program developers, and others concerned with vulnerable children whose difficult temperaments, developmental limitations, and/or challenging behavior may demand extraordinary skill and commitment from parents and caregivers.

Assessment, Treatment, and Prevention

Infant mental health practice can be thought of in terms of assessment, treatment, and prevention activities.

Assessment

Twenty-five years of research regarding assessment of infant behavior and development speaks to the importance of assessing infant-caregiver relationships (Clark, 1993; Zeanah, Larrieu, Heller & Valliere, 2000). Assessment should look at both the overt patterns of interaction that characterize the relationship of a particular child and adult, as well as the subjective experience of each member of the dyad. In other words, assessment should include evaluation of both behavior and the meaning of behavior for the dyad in question (Stern-Bruschweiler & Stern, 1989).

Domains of the parent-child relationship have been proposed by Emde (1989) and modified for use in relationship

assessment by Zeanah, Larrieu, Heller & Valliere (2000). In this model, certain parent behaviors are conceptually linked with emerging infant behaviors and qualities. Thus, parents' emotional availability is associated with infants' patterns of emotion regulation. Parents' nurturance and warmth are associated with infants' sense of trust and security. Parents' response to distress is related to infants' learning to seek comfort for distress.

Further, parents' protection of their infants is related to the infant's feelings of safety and the later development of the capacity for self-protection. Parents are important play partners for their infants, and play is an important domain of the infant-parent relationship. Parents also are teachers of their infants, and these efforts relate to infants' curiosity, sense of mastery and interest in learning. Parents provide structure, routines and instrumental care in order that their infants develop a sense of predictability and the capacity for self-regulation. Finally, parents set limits and discipline as needed to assist young children to develop self-control.

These domains can be assessed through a combination of parent report and observation of infant-parent interaction in naturalistic and clinic settings. Naturalistic settings — including homes, child care, and community program settings — offer the advantages of observing interaction in "real-world" contexts, without constraining behavior of the child and adult. Clinic settings, on the other hand, afford clinicians opportunities to structure situations to elicit behaviors of interest. Clinic interactional assessments generally include both less and more structured activities for parent and child, in order to determine how each of these is negotiated by the dyad (Clark, 1993; Zeanah et al., 2000).

The meaning of the child's behavior for the parent may be assessed by careful attention to how the parent perceives and experiences the child. Clinicians may use structured interviews (Zeanah & Benoit, 1995) and/or less formal observations to explore not only the content of parents' perceptions but also qualitative features, such as coherence, emotional tone, and flexibility.

Treatment

Treatment of already identified mental health problems in infants and toddlers may be focused primarily on changing the infant (Benoit, 1993), the parent's experience, (Cramer, 1997), or the infant-parent relationship (McDonough, 2000; Lieberman, Silverman & Pawl, 2000). Stern (1995) observes that these different forms of intervention all are concerned with changing the infant-parent relationship as a way of changing infant behavior and ensuring that the changes are enduring. Explicit efforts to work with parent and infant together on changing their relationship in order to change the infant begin with developing a good "working alliance" between parents and therapist — that is, a shared interest in working together in the best interest of the child. The relationship between the therapist and the parent becomes an important component of treatment, although most therapeutic

effort is concerned with appreciating the parent's emotional experience of the young child, and the young child's experience of the parent.

Treatment of established infant mental health problems are concerned with here-and-now resolution of symptoms and distress, but they also are concerned about infants' developmental trajectories. For this reason, infant mental health treatments are concerned simultaneously with present and future adaptation of the child.

Prevention

Prevention of future mental health problems generally focuses on infants at high risk for the emergence of these problems even before they become manifest. Preventive interventions emphasize altering infant and parent behaviors and family functioning in order to preserve or restore infants to more normative developmental trajectories. Sometimes "intrinsic" infant risk factors, such as difficult temperament, are not preventable, but prevention efforts can focus on possible adverse consequences associated with difficult temperament, such as the emergence of behavior problems. Prevention efforts may target a range of risk factors in the caregiving environment — for example, maternal depression or abuse and neglect — known to be associated with poor developmental outcomes.

A classic example of a prevention effort directed at the reduction of abuse and neglect in a high-risk population is the work of Olds and his colleagues. They pioneered a public health nurse home visitation intervention with first-time, impoverished mothers. The preventive intervention began in pregnancy and continued through the child's second birthday; it focused comprehensively on personal health, environmental health, quality of caregiving for the infant, maternal life course development, and social support. In addition to other findings, this program demonstrated an 80 percent reduction in child maltreatment among families from birth through the child's second birthday, a 56 percent reduction in health care encounters for accidental injuries in children, a 43 percent reduction in subsequent pregnancies, and a reduction in anti-social behaviors among target children at age 15 years (Kitzman et al., 1997; Olds et al., 1997; 1998). Importantly, the program costs were recovered with benefits by the time the target child was four years old.

Young children who are abused and neglected are at dramatically increased risk for poor outcomes across a variety of domains (Cicchetti & Toth, 1995). Efforts to intervene once abuse and neglect already has occurred to minimize adverse outcomes in children are an example of secondary prevention. For example, our group recently demonstrated that a comprehensive, individualized, relationship-focused preventive intervention dramatically reduced the rate at which children who were returned to their parents after being in foster care later returned to the system (Zeanah et al., 2001). Not only were the maltreated children less likely to return to foster placement a second time, maltreating

mothers also were less likely to have another child placed in foster care subsequently.

Definitions

Our review of infant mental health concerns – both conceptual and practical – provides a context for considering definitions of infant mental health as a characteristic of infants, and as a field of inquiry and practice.

Infant mental health may be defined as the state of emotional and social competence in young children who are developing appropriately within the interrelated contexts of biology, relationships, and culture. This definition emphasizes the infant as imbedded both within multiple contexts and as developing and changing. Normal developmental trajectories for various domains serve as reference points for assessing infant competence. Threats to infant mental health are created by intrinsic or extrinsic factors that increase the risk of suffering, developmental deviance, or maladaptation.

The field of infant mental health may be defined as multidisciplinary approaches to enhancing the social and emotional competence of infants in their biological, relationship, and cultural contexts. Infant-caregiver relationships are the primary focus of assessment and intervention efforts, not only because infants are so dependent upon their caregiving contexts but also because infant competence may vary widely in different relationships. Assessments in infancy always are considered a form of intervention, as they may have important impacts on both infant and family. Moreover, intervention efforts always involve prevention because the infant is considered as constantly developing, and the infant's developmental trajectory must be attended to in addition to here-and-now adaptation.

Infant mental health is multidisciplinary because the complex, interrelated nature of human development and its deviations requires expertise beyond the capabilities of any particular discipline. For the same reason, it is likely that the field of infant mental health will remain pluralistic, a subspecialty within a number of different disciplines rather than an integrated and distinct discipline itself. The complexity of the problems of infants and toddlers must be matched by the comprehensiveness of our efforts to minimize their suffering and developmental deviations, and to enhance their development and promote their competence. ♦

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A Developmental Psychiatrist Looks at INFANT MENTAL HEALTH CHALLENGES FOR EARLY HEAD START: *Understanding Context and Overcoming Avoidance*

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PHOTO: MARILYN NOLT

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I would like to share how a developmental psychiatrist's way of thinking might contribute to the work of Early Head Start and other community programs for infants, toddlers and their families.

What is the job description of a developmental psychiatrist? Such a person attends to the problems and prevention of mental disorder *throughout* the lifespan—early in life and later, in children, parents, and grandparents. Moreover, a developmental psychiatrist thinks about health as well as illness: 1) pathways that lead to competence, as well as pathways that lead to disorder; and 2) factors that promote healthy development as well as factors that are involved in risk and protection with regards to the onset, course, and treatment of mental disorder. A developmental psychiatrist involved in infant mental health also has a dual responsibility, to attend both to the “now” and to the “future.” It is important to both alleviate current problems and suffering of very young children, and address adverse circumstances that might interfere with the achievement of expectable developmental competencies or lead to identifiable mental disorders. Finally, an important feature of clinical

work in infant mental health necessarily consists of understanding and treating the child-in-context. Considerations of context include appreciating the child with parents and the child within other relevant caregiving relationships, as well as thinking about developmental “systems” and looking at changes over time. It should also be mentioned that such work is necessarily multigenerational and multidisciplinary.

I have worked for nearly four decades as a developmental psychiatrist and consider myself fortunate to have been closely involved with the conceptualization and continuing study of new programs in Early Head Start. My experience suggests two themes I would like to emphasize in this essay. The first is understanding the child in context, as introduced above. The second concerns a different topic—namely our difficulties in overcoming a tendency to avoid addressing mental health problems.

Understanding the Child in Context

The theme of context has two aspects for emphasis: that of development and that of embeddedness in relationships.

We might state this in the form of a principle: It is important to understand the very young child in the context of early development as well as in the context of that child's relationships with family, caregiving staff, and the larger community.

The context of early development

What, precisely, do we mean by "development"? A few years ago, a group of senior researchers of human development offered this definition:

Development consists of change within individuals over time. It involves increasingly organized complexity. As such, it also involves processes of differentiation (divisions into subsystems), integration (articulation of wholeness), and hierarchicalization (successive ordering of parts and wholes). Moreover, development necessarily involves dynamic exchanges within the environment. As a consequence of this definition, human behavioral development must therefore be considered not only in its biological context – wherein adaptive aspects of interactions involving genetic expression, maturation, physiological patterning, and cognitive construction are salient – but also in its socio-cultural context – wherein adaptive aspects of interactions with an arrangement of social roles, networks, and environments are salient. Human development must also be considered not only from the perspective of continuity, but from the perspective of transformational change; not only from the perspective of successful adaptation and health, but from the perspective of unsuccessful adaptation and disorder¹.

This definition offers us two important perspectives on the developmental context for infant mental health. First, we must think about infant mental health in terms of the development of competencies. It involves, for example, increasingly organized complexity in the acquisition of abilities to learn and to accumulate knowledge, to regulate one's emotions, and to build social skills within relationships. It also involves the child's ability to gain satisfaction during exploration, social exchanges, and play. Second, we must think about infant mental health in terms of *successful adaptation in the midst of challenges and opportunities*. Successful behavioral adaptation involves the ability to respond meaningfully to changing circumstances across time – simply put, the ability to be flexible.

At this point, our consideration of early development turns to pathology. From the perspective of developmental psychiatry, pathology has two core features that distinguish it from mental health. The first is *rigidity*, or the inability to change. We recognize the presence of pathology when an individual has trouble responding appropriately in the midst of new circumstances. The second core feature of pathology is *pain or suffering*. Both rigidity and pain interfere with development as we have defined it. These two features of pathology are especially compelling when we remember the typically rapid pace of development during the earliest years.

We can summarize a developmental way of thinking about infant mental health by asking two questions: 1) What do we want to strengthen? and 2) What do we want to prevent?

We want to strengthen individual pathways for development, including:

- Motivation for learning and positive experiences with exploration;
- Motivation for reciprocity in relationships, communicating, and positive experiences with caring and support;
- Confidence in the use of emotions for self and other that includes expectations of meaningful emotional experiences with significant others, dealing with conflict, and the capacity for play and imagination;
- Character-sense that includes planning skills, confidence in mastering challenges, effectiveness in social exchanges, and a sense of "conscience" or responsibility; and
- Behavior that protects safety and health.

We want to prevent developmental compromises and problems of adaptation in:

- Learning (e.g., learning inhibitions and failures);
- The formation and maintenance of relationships (e.g., relationship disturbances and disorders as described in Axis II of DC:0-3 [ZERO TO THREE, 1994]);
- Emotional regulation (e.g., disorders of affect as described in Axis I of DC:0-3; internalizing problems of behavior);
- Behavioral regulation (e.g., externalizing problems in behavior, including planning difficulties, dysregulation of aggression, problems of reciprocity and empathy); and
- Risk-taking and attention to physical health (e.g., accidents and injuries, lack of immunization, poor utilization of health services, poor nutrition, substance abuse).

The context of the child's relationships

What can we say about the young child's relationship context? In 1994, the Advisory Committee on Families with Infants and Toddlers articulated the guiding principles for Early Head Start. The Committee's report emphasized that the young child cannot survive – let alone thrive – without the nurturance, protection, and regulation provided by the caregiving environment (Advisory Committee, 1994; also see conceptual review in Sameroff & Fiese, 2000). On the positive side, the Advisory Committee described how caregiving relationships contribute to infants' and toddlers' emotional and psychological health. Their language seems worth quoting:

Within the context of caregiving relationships, the infant builds a sense of what is expected, what feels right in the world, as well as skills and incentives for social turn-taking, reciprocity, and cooperation . . . During the toddler period, the child, through repeated interactions with emo-

¹The group, as part of the MacArthur Research Network on Early Childhood Transitions, consisted of Mark Applebaum, Elizabeth Bates, Kathryn Barnard, Robert Emde, Marshall Haith, Robert Hinde, Joan Stevenson-Hinde, Jerome Kagan, Marion Radke-Yarrow, and Arnold Sameroff.

tionally available caregivers, also begins to learn basic skills and self-control, emotional regulation, and negotiation. Empathy for others and prosocial tendencies for caring and helping also develop during toddlerhood, as well as the emotions of pride and shame; experiencing and learning about these capacities require responsive caregiving in the midst of life's inevitable stresses and challenges. . . . A sense of pleasure, interest and exploration, early imaginative capacities, and the sharing of positive emotions also begin in infancy – all of which require repeated and consistent caregiver relationship experiences and form a basis for social competence that carries through toddlerhood and the preschool period . . . (Advisory Committee, 1994, p. 7).

More recently, a panel of experts convened by the National Research Council and Institute of Medicine and charged with the task of integrating the science of early childhood development, described the risks to healthy development that can arise from the context of the child's relationships:

. . . (Y)oung children who do not have a relationship with at least one emotionally invested, predictably available caregiver – even in the presence of adequate physical care and cognitive stimulation – display an array of developmental deficits that may endure over time. Some children develop intense emotional ties to parents and other caregivers who are unresponsive, rejecting, highly erratic, or frankly abusive. These relationships can also be a source of serious childhood impairments, ranging from problems with focused attention and problem-solving to difficulty in forming healthy relationships, failure to thrive, and a variety of serious psychiatric disorders. The remarkable recovery that many such children demonstrate, once they receive responsive and consistent caregiving, provides some of the strongest evidence of the power of these earliest relationships (Shonkoff and Phillips, 2000; also see the April/May 2001 issue of Zero to Three.)

All infant mental health interventions seek to support and improve early caregiving relationships. We have learned from both practice and research that those interventions that are helpful involve the influence of relationships on other relationships – in other words, practitioners who work with infants, toddlers and their families make an

at a glance

- It is important to understand the very young child in the context of early development.
- It is important to understand the very young child in the context of that child's relationship with family, other caregivers, and the larger community.
- It is difficult – but essential – to recognize suffering and pain in young children.
- Consultation, coaching, and reflective supervision can help staff recognize and address mental health problems in infants and young children.

impact by strengthening caregiving relationships that, in turn, can be internalized by the child (Emde, Korfmachner & Kubicek, 2000; Stern, 1985; Sameroff & Emde, 1989). The network of relationships in the community – including those involving parents, staff, and community partners in Early Head Start and child care programs – also acts to support the young child's social and emotional development.

Recognizing and Addressing Mental Health Problems in Very Young Children

The second theme of this essay is of a different order and is a more troublesome one. It is often painful and difficult to recognize and address mental health problems in infants and young children. This was given recognition by an Early Head Start program director who recently said to me, "As difficult as it is, it's time to address the uncomfortable." My colleague was confronting how hard it is for us to admit that infants and young children suffer, and that they can experience pain and disorganization, as well as a narrowing of their adaptive capacities and impediments to their development. I would like to direct attention to four kinds of mental suffering in young children:

- Pain and distress from trauma, abuse, or loss of a caregiver;
- Misery from neglect;
- Suffering from cumulative stress; and
- Suffering from lack of opportunity.

We have problems in recognizing all of these kinds of suffering. But young children do suffer, often horribly. All too often we would rather not be confronted with our own pain and sense of helplessness in the face a baby who is miserable or in miserable circumstances. In talking about this tendency to pediatricians over the years, I used to use a phrase about our struggles in "coming to grips with the painfully obvious." More recently, I have become more aware of the latter two kinds of suffering. Sadly, we seldom try to measure suffering from cumulative stress or lack of opportunity.

Why has it been so difficult to recognize suffering and pain in young children? As a clinician and researcher, I can say that it is not that adults do not resonate with the pain. Rather, we struggle to avoid it. We do not want to believe that infants and young children suffer because their helplessness all too often confronts us with our own helplessness. As a result, we are often literally unable to recognize evidence of sadness and emotional "shutdown" in the infants and toddlers we see in our daily work.

When we are able to overcome our denial of children's suffering, we can bring about important change. It is only within the last 40 years that we have recognized child maltreatment — including child physical abuse and trauma, child neglect, and child sexual abuse — as one of the most pervasive public health problems in our nation. Rene Spitz described developmental delays, depletion, and depression in

infants who were deprived of personal caregiving in orphanages or who were separated abruptly from their mothers after six months of age (Spitz, 1946). His descriptions initially met with disbelief and disregard, and probably would not have been believed even by sympathetic colleagues had he not filmed the depressed infants he saw. The diagnostic category of depression in children younger than 10 years did not become accepted by the American Psychiatric Association until 1994. This was the same year in which ZERO TO THREE published its *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-3) (ZERO TO THREE, 1994), a descriptive classification system based on current knowledge and practice which appreciates that very young children's mental health disorders are embedded in caregiving relationships. The DC: 0-3 approach to assessment includes an evaluation of a number of dimensions of developmental functioning, as well as the evaluation of very young children's suffering and the factors that may interfere with their adaptive capacities. Recognizing the realities of child maltreatment has led to the establishment of legally binding systems for its recognition, reporting and interventions. If we can overcome our denial of infant suffering and problems of adaptation and development – as advances in infant mental health theory, research, and practice can help us to do – we may be able to design and establish community-based systems of care to achieve the twin goals of strengthening pathways to healthy development and preventing developmental compromises and serious mental health disorders.

With this background, we should not be surprised that staff in Early Head Start, child care, early intervention, and other community programs that serve young children and families may have difficulties in recognizing infant suffering and in talking about mental problems and pathology. In addition to the struggles in recognizing infant suffering that we have already discussed, staff often fear that "labeling" a child or family will result in stigmatization, devaluation, or blame. A lack of knowledge about mental health problems and diagnosis also contributes to avoidance, and the training of infant/family practitioners seldom includes the recognition and management of mental disorders. Fortunately, difficulties of recognizing and helping with mental health problems in children and their parents in Early Head Start and other community environments are by no means insurmountable. A culture of consultation, coaching and reflective supervision in infant/family programs, where it exists, can offer opportunities to staff for sharing, support and learning about mental health problems. Trained infant mental health specialists, working on site in early childhood environments, can provide infant mental health supervision and also can consult daily with staff, families, and children. Sufficient skilled support can help Early Head Start and other infant/family settings to facilitate a network of consistent nurturing relationships that, in addition to directly influencing the child, also influence other relationships – especially

the relationship between child and parent (See Bertacchi, Emde, & Mann, this issue, for a more detailed discussion of elements of an environment that facilitates infant mental health.)

Conclusions

Many thoughtful community programs are providing innovative and effective ways to help infants and toddlers develop strengths in the midst of consistent caring relationships. Such programs, I believe, are shifting the odds toward more healthy and adaptive outcomes for children. The time now seems appropriate for addressing the mental health needs of very young children. We know that recognizing problems, let alone helping with them, can only be done by attending to the child in context, and by addressing the mental problems not only of children but also of parents and other adults in the caregiving environment. Support – in the form of training, consultation, coaching, and reflection – is the key to overcoming reluctance to discuss conflicts, difficulties, emotional problems and entanglements. It is time to use the knowledge and skills we have been developing in recent decades in order to address the uncomfortable. It is time to learn to recognize suffering in babies and toddlers, to heal, and to prevent later adaptive compromise and disorder. In order to do this, it is also time to give more attention to ongoing support and time for staff to engage in reflective supervision. ♦

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FATHERS AS FACILITATORS OF INFANT MENTAL HEALTH:



Implications for Early Head Start

PHOTO: MARILYN NOLT

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Although knowledge of the father's impact on child development lags far behind knowledge of the mother's impact (Lamb, 1987; Lamb, Pleck, Charnow & Levine, 1987) enough studies have been published in the research literature to support a number of broad-sweep generalizations. These statements are best conceptualized as working hypotheses. It is essential to remember that the research supporting these generalizations disproportionately involves data obtained from white, middle-class fathers. Recent research suggests that:

- Men are motivated to have children for psychological reasons, not for social or economic reasons (Mackey, 1996). Simply put, men like children.
- Although fathers are not particularly involved with infants, they become more involved as children reach the toddler years and gain the motor and language skills to engage in active forms of physical play (Belsky, Rovine & Fish, 1989).
- Fathers can and do perform routine caregiving tasks with their infants (Parke, 1979), but when the mother is present, fathers yield caregiving management to her (Mackey, 1996).

An opportunity to learn about a much more ethnically diverse and low-income sample of fathers of infants and toddlers is provided by the National Evaluation of Early Head Start (NEEHS). The sample includes biological fathers living with their children, biological fathers who are not living with their children, and "social fathers" – men who are not the biological fathers of children eligible for Early Head Start, but who are identified by the mother as having a "father role" in the life of the child. Preliminary data give an overwhelming impression that fathers of two-year-olds in the NEEHS study, like other fathers, are emotionally invested in their children, regardless of their biological or social status. These fathers report that they brag about the child, carry a picture of the child, think about the child, think holding the child is fun, and enjoy going places that the child likes. When asked about their attitudes and beliefs, these fathers say that mothers are "naturally" more sensitive than fathers to their children's needs. However, they also say that:

- fathers should be as involved in child rearing as mothers;
- fatherhood is rewarding; and
- the father's role extends beyond the simple provision of economic resources.

A second set of working hypotheses from the father-research literature includes the following:

- Across a wide range of cultures, when fathers have access to their children, they take advantage of it (Mackey, 1996).
- Physical distance between fathers and their children decreases father involvement (Lerman & Sorensen, 1996).
- When the father's role as a breadwinner is compromised, he is less likely to be involved with his children. When such fathers are not living with their children, mothers are likely to limit their access to them (Lerman & Sorensen, 1996; Mackey, 1996).
- As mothers' economic independence increases, fathers are less likely to be involved with their children (Lerman & Sorensen, 1996).

Once again, data from the NEEHS study seem to be consistent with these working hypotheses. We asked all three groups of fathers (biological fathers living with their children, biological fathers who are not living with their children, and "social fathers") about their involvement in 28 different activities. These included language interactions (singing songs or nursery rhymes; reading or telling stories); active play (teasing, playing with a ball, playing

Across a wide range of cultures, when fathers have access to their children, they take advantage of it.

with toys, tossing in the air, going for a walk); routine child care (changing diapers, putting to bed, bathing, tending during illness); and social and community engagement (visiting with relatives or friends, going to a restaurant, attending a community program or religious service). We asked fathers to list activities in which they were involved "at least daily" and those in which they participated "at least monthly."

All of the fathers report being very much engaged in the lives of their children. The data are completely consistent with the cross-cultural dictum, "When men have access to their children, they take advantage of it." Nevertheless, the NEEHS data suggest that non-residential biological fathers are less involved with their children than are biological fathers living with their children or social fathers. The issue is "being there" – 91 percent of resident biological fathers reported that they saw their child at least once or twice a week; only 55.6 percent of non-resident biological fathers reported seeing their child that frequently.

The Roles of Fathers

In addition to looking generally at fathers' attitudes toward young children and their level of involvement with their babies and toddlers, some researchers have focused on fathers' roles. Jain, Belsky, and Crnic (1996) identify four types of fathers, defined by their preference for caregiving involvement. They describe:

- the Caregiver – involved with routine and basic care;
- the Playmate-Teacher – teaching young children how to control their behavior within the context of play and games with rules;
- the Disciplinarian – focusing on controlling and socializing the child's behavior; and
- the Disengaged Father – apparently uninterested in providing care.

at a glance

- The National Evaluation of Early Head Start (NEEHS) offers an opportunity to learn about a much more ethnically diverse and low income sample of fathers than researchers have studied previously.
- Fathers play many roles – Provider/Protector, Playmate, Disciplinarian, and Caregiver.
- Preliminary NEEHS data suggest that the vast majority of EHS-eligible fathers are very much involved with their toddlers.
- Behavioral Monitoring and Community Systems Networks interventions may support fathers as facilitators of their infants' and toddlers' mental health.

One might also add "The Provider" to this list, noting the historical role that fathers have played as breadwinner (Lamb, 1987).

Qualitative data obtained from interviews of low-income fathers of toddlers seem consistent with these role distinctions. Summers, Raikes, Butler, and their colleagues (1999) characterize roles played by fathers from low-income families as Provider/Protector (financial support, protection, "being there"); Playmate (play); Disciplinarian (discipline); and Caregiver (nurturance). Almost no fathers report attitudes and patterns of behavior characteristic of disengagement. However, current evidence suggests that when mothers and fathers no longer have a meaningful relationship, fathers are likely to become increasingly distant from their children. This is an issue that Early Head Start and other community-based programs should keep in mind as they try to support strong connections between fathers and children.

Whether these patterns are unique to the United States or unique to fathers of children in low-income families remains to be determined. Evidence suggests that fathers' roles may vary more within cultures than between cultures, but data are scant. For example, a recent survey of 386 studies of infant development in cultural context produced only 7 that explicitly included fathers, and not all of these focused on the father's role as caregiver (Fitzgerald, Johnson, Van Egeren, et al., 1999). Gaps in the research literature are also apparent when we try to understand fathers as facilitators or, possibly, underminers of the mental health of their young children. For example, studies have consistently linked father absence with negative outcomes for children, and studies of antisocial behavior and substance abuse among fathers who are in the home show clear links to behavior problems in preschoolers that continue to early adulthood. However, researchers have not studied what fathers do that promotes resistance or resilience against negative outcomes.

Fathers, Infant Mental Health, and Early Head Start

As noted above, preliminary data from the NEEHS fathers study suggests that the vast majority of fathers are very much involved with their toddlers. As a comprehensive, intergenerational program, Early Head Start offers an opportunity to focus on the parent-child relationship as a way of generating immediate positive outcomes related to infants' and toddlers' health status, emotional well being, social behavior, and cognitive competence. When we think specifically about fathers, however, we must remem-

ber that we do not know whether intervention models based on a home visitor/mother relationship will be effective with fathers. We must also acknowledge that Early Head Start programs are not staffed to address parental mental health problems; fathers with substance abuse disorders and/or with antisocial personality disorders are difficult to treat in any context.

Two intervention approaches seem especially suited for young children with mental health problems and for fathers—Behavioral Monitoring and Community Systems Networks.

Behavioral Monitoring

With appropriate training and support, Early Head Start staff can teach children how to restrain their aggressive, impulsive, and uninhibited behavior. This approach will enhance children's coping strategies, build resilience, and enable them to engage the environment in constructive and beneficial ways. Teaching compliance and respect for authority involves modeling and reinforcement. Some impulsive, acting-out children—particularly those who come from homes in which there is a high level of conflict and/or antisocial behavior—need exposure to new role models in order to challenge the mental representations they are constructing about appropriate adult behavior. This is especially important for boys (Fitzgerald et al., 2000). Furthermore, very young children need to understand clearly what is acceptable and unacceptable behavior, and to receive discipline when those standards are violated.

In the context of Early Head Start, a starting point for behavioral monitoring with fathers may be to develop intervention programs that are anchored in what we currently know about fathering behavior. For example, if fathers decrease their involvement with children when a woman is present, it makes sense to use men as home visitors to families with resident biological or social fathers. If fathers are specialists in rough-and-tumble play, recruit them to teach EHS toddlers soccer and other high-energy sports. If non-resident fathers gradually distance themselves from their children because they lose their status as providers and protectors in the home, find ways to give them provider and protector roles within Early Head Start—for example, as "lifeguards" with significant responsibilities for children's safety on the playground or on excursions.

Community Systems Networks

Community building is one of the four cornerstones of the Early Head Start program identified by the Advisory

The potential exists for building the father-child connection among families in Early Head Start and other community programs.

Committee on Services for Families with Infants and Toddlers. Every Early Head Start program should be an active member of its community's human services system, and if a community does not have such a system, Early Head Start should create one, involving, at a minimum, public health, mental health, social services, education, business, media, law enforcement, the judicial system, the faith community, and parents. Members of a community network typically meet monthly to exchange information, discuss interagency referrals, and identify community programs that may be useful in meeting specific needs within the service system. By serving as a hub for referrals throughout the system, a community network can help to develop a safety net for all children and families involved with Early Head Start.

When a community systems network includes Early Head Start, community programs targeting men, and the community's mental health providers, the potential exists for building the father-child connection among families in Early Head Start. An EHS program could use a community systems network to begin a community-wide program emphasizing the positive contributions that fathers make to child development, and then involving area service clubs in enhancing the presence of men in Early Head Start settings. For example, an Urban League chapter or Big Brothers program might "adopt" an EHS program and work with staff to provide opportunities for male involvement with infants and toddlers. Within a community systems network, Early Head Start can serve as an information and referral service for participating families and can promote fathers' access to appropriate programs in the community.

Conclusion

As providers, protectors, caregivers, and socializers, fathers play many roles in facilitating the healthy emotional development of infants and toddlers.

The challenge to Early Head Start and other community-based programs is to find ways to reduce barriers to father involvement and actively support innovative efforts to enhance male involvement in the lives of infants and young children. Providing opportunities for fathers to become involved in ways that are meaningful to them is likely to serve a larger goal—strengthening fathers' connections to their own children. ♀

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PHOTO: MARILYN NOEL

THE SOCIOCULTURAL CONTEXT OF INFANT MENTAL HEALTH *in African American Families*

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"Children are the reward of life." Proverb from Zaire

Within recent decades, the population of the United States has become increasingly culturally diverse (Fisher, Jackson, & Villanuel, 1999; Hernandez, 1999). Whether they were born here or arrived with immigrant families, infants and toddlers from a wide range of ethnic, linguistic, and cultural backgrounds are living in family contexts that vary greatly with respect to size and structure (e.g., a single mother and her baby; a large, multigenerational, extended family household) and that offer young

children different kinds of developmental supports and challenges (e.g., multiple attachment figures; varying degrees of cohesion or conflict among family members). Thus, there is a growing need to provide culturally responsive infant mental health services and programming to families of infants and toddlers of diverse backgrounds (Randolph & Koblinsky, 2000; Surgeon General's Report, 2000).

Culturally responsive programming incorporates "the importance of culture, the assessment of cross cultural relations, vigilance toward the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs"

(Cross, 1985, p. 1). Although many scholars support the importance of such programming, they also recognize serious shortcomings in the knowledge base examining how culture affects the developmental pathways of infants and toddlers (Phillips & Cabrera, 1996). Several recent volumes emphasize the need to explore how cultural values and childrearing practices influence infant and child development (Fitzgerald & Osofsky, 2000; Shonkoff & Phillips, 2000; Zeanah, 2000). In their volume Shonkoff and Phillips (2000) further underscore these points by noting that "the extent to which both the capacity and the resolve to learn more about the relationship between culture and early childhood development are strengthened will determine the ability to understand the rich diversity of human cognitive, social, emotional, and moral development beginning in the earliest years of life" (p. 69).

In this article we focus on African American families to illustrate how culture might influence parenting behaviors, attitudes toward mental health, mental health help-seeking behavior, and children's mental health outcomes. African American families now represent 12.7% of the American population (U.S. Bureau of the Census, 1995). African American children may be disproportionately at risk for mental health problems because they are more likely to live in poor families and experience persistent poverty than children in families from other cultures (e.g., Duncan & Rodgers, 1988; U.S. Bureau of the Census, 1995). Yet, there is currently a paucity of research examining how African American families raise young children within a sociocultural context. Educators and researchers also know relatively little about the normative development of African American children, the parenting values and behaviors of their parents, or the characteristics of the neighborhoods in which they live. In particular, there are relatively few studies exploring the strengths and resources of African American families that reduce risks, protect children, and contribute to optimal development (Allen & Majidi-Ahi, 1989). Information is especially needed about parents and children's mental health during the early years, because the influence of the parent's (usually defined as mother's) mental health status on children's outcomes is well documented and recent brain research suggests that child functioning from preschool onward hinges significantly on experiences before age three (Carnegie Task Force, 1994).

Given the limited knowledge base on the mental health of young African American children and other children of color, this article explores the sociocultural context of African American infant/toddler development in an effort to identify factors that contribute to understanding and addressing infant mental health from a sociocultural perspective. The purposes of this article are to increase awareness of how expectations and perceptions of infant mental health might differ by culture, and discuss the importance of understanding how the culture of the family and community can be used as a resource in addressing infant mental health issues.

This perspective will have implications for the design of preventative intervention programs, family and community outreach, and early research and policy in early childhood mental health.

This article reviews contemporary theoretical frameworks that guide our analysis of early childhood development and an Africentric model of development that has guided African American psychologists in their mental health research efforts and practice. This article also reviews research that reflects the importance of understanding cultural variations in experiences, beliefs and practices that might influence infant mental health. Lastly, the article presents a framework that can be applied to promote cultural competence in services and programs in order to more appropriately address the mental health needs of infants and families of diverse backgrounds.

Theoretical and Conceptual Frameworks

Traditional and integrative models

One of the most widely used conceptual models of development is the ecological approach. The social ecology model (Bronfenbrenner, 1986), also labeled a contextualist model, views child outcomes as dependent upon characteristics of the child, parent, family, and community, as well as the complex interactions among these variables. Some have argued that traditional ecological models are limited because issues such as social history, social location, majority/minority status, and discrimination are excluded or so external that they make the model irrelevant. Therefore, an expanded conceptual framework—the integrative model of the development of competence in children of color—was developed by Garcia Coll et al. (1996) to account for such variables. This model considers the centrality of cultural form and meaning, and extends the role of family and kin networks beyond that seen in traditional ecological models.

A central premise of the integrative model is that families of color develop adaptive cultures—or systems of goals, values, and behaviors—that set them apart from the dominant culture. These coping mechanisms, which develop in

at a glance

- Early development is shaped by ecological factors – parents' goals, values and behaviors; parental work demands; parental mental health; family organization; family strengths; social support networks; and neighborhood contexts.
- At least 10 dimensions comprise the African worldview – spirituality, communalism, harmony, expressive communication, affect sensitivity, rhythmic movement, verve, stylistic expressiveness, time as a social phenomenon, and positivity.
- As it evolves, the cultural competence framework can be used to develop more responsive mental health services for families and children of color.

response to cultural/social stratification, are a product of both the group's cultural/political history and the demands of the immediate environment. Such demands directly influence family processes and child characteristics, which interact to influence the development of child competence. At the heart of the integrative model is the assumption that children of color cannot be judged by some universal standard, but must be understood in the context of their specific ecological circumstances. Later in this article we will focus on a number of these contexts at the parent, family, and neighborhood levels in an effort to identify how culture may differentially contribute to outcomes among African American infants. Before presenting this review, we discuss an Africentric conceptual framework that has been used for decades by African American psychologists in examining adult mental health issues and which incorporates dimensions of the African worldview. This Africentric model of development is presented to provide an additional framework for better understanding how cultural values may shape parenting behaviors and practices that have implications for African American infants' mental health.

The Africentric model of development

Many researchers have noted the failure of traditional social science approaches to tap the underlying cultural processes that guide the behavior of African American parents and their children (e.g., Baldwin, 1981; Nobles, 1985). In response to this problem, several scholars have developed Africentric models for understanding African American individual, family, and community development (Akbar, 1979; Asante, 1980; Baldwin, 1981; Hilliard, 1997; Myers, 1988; Nobles, 1985). These models recognize that there are strands of ancient African history, culture, and philosophy that manifest themselves in contemporary African American life and communities (Staples & Johnson, 1993). Central to these models is the notion of a "world view, [a] complex, interacting set of values, expectations, and images of oneself and others, which guide and are guided by a person's perceptions and behavior, and which are closely related to...feelings of well being" (Frank, 1977, p.27). This focus on world view is not unique to African Americans but extends to other racial/ethnic groups in that most attempts to describe these other groups also begin with identifying preferences or characteristics linked to the group's region of origin (Frank, 1977; Shonkoff & Phillips, 2000).

The African worldview includes numerous dimensions that reflect ways in which African American people may think, feel, and act. Although some of these dimensions are found in other groups, it is the unique blend that defines the

particular culture. It should also be noted that there are variations in the degree to which members of racial/ethnic groups adhere to the dimensions of their group's worldview. At least ten dimensions comprise the African worldview (see Randolph & Banks, 1981 for a review) and may be helpful in interpreting African American parents' goals/behaviors and developmental outcomes among their infants.

1. **Spirituality**, or belief in a Supreme Being or supreme powers, goes beyond religiosity to focus on the qualities of people rather than material possessions. For example, when asked what they want for their children in the future, some African American mothers may answer "to be happy" (a spiritual goal) rather than to "graduate from college" (a material goal).
2. **Communalism** or an interpersonal orientation reflects an emphasis on group over individual goals, an emphasis on cooperation rather than competition, and people-focused versus task-focused activities. Mothers with this orientation may place a high value on young children learning to share their toys or engaging in play activities that involve other children.
3. **Harmony** refers to the importance of integrating one's life into a whole, recognizing one's interdependency with the environment, and seeking unity rather than control.
4. **Expressive communication or orality**, emphasizes transmitting and receiving information orally, through rhythmic communication and call and response.
5. **Affect sensitivity** to emotional cues reflects the integration of feelings with cognitions, and a synthesis of the verbal and nonverbal. For example, parents may signal children to alter their behaviors with a simple gesture or look.
6. **Rhythmic** movement is expressed in gross motor behavior, and reflects an interest in flexible yet patterned action.
7. **Multidimensional perception or verve** is illustrated in the preference for stimulus variety in learning (e.g., visual, auditory, tactile, motor); both parent and child value experimentation.
8. **Stylistic expressiveness** refers to the valuing of the individual's unique style, flair, or spontaneity in expressing oneself (e.g., the way one walks, talks, or wears an article of clothing), but this value is emphasized only when it facilitates group goals.
9. **Time as a social phenomenon** reflects the view that time is spiritual, not material or linear. For example, an event begins when the first person arrives and ends when the last person leaves, rather than at fixed

The Africentric model of development provides a framework for understanding how cultural values may shape parenting behaviors and practices.

points on a clock. There is also recognition of the linkages of present time to the past and the future.

10. **Positivity** refers to the desire to see good in all situations no matter how bad they seem on the surface. This positive perspective is thought to stop self-defeating behavior and generate positive problem-solving activity.

Proponents of this model acknowledge that there is much work to be done to link dimensions of a worldview based geographically in Africa with cultural dimensions of contemporary African American behavior. Interestingly, Africentric cultural characteristics have already been associated with positive functioning among African American school-age children (Boykin, 1983), adolescents (Roberts, 1997), and adults (Gary & Berry, 1985). Moreover, African American parents who engage in racial and ethnic socialization practices that reflect Africentric values have been found to have more socially and academically competent children than African American parents who have not adopted these practices (Greene, 1992; Spencer, 1983; Stevenson, 1994).

The dimensions of an African worldview may shape African American families' and communities' perceptions of mental health as well as their individual behavior, help-seeking patterns, and parent-child interactions. As noted earlier, not all African American parents may value these dimensions, so it is important to understand within-group differences in parenting beliefs that have implications for infant's mental health. Moreover, some contemporary social conditions that disproportionately affect African American families (poverty, HIV/AIDS, substance abuse, community violence) may make it difficult to practice values that have traditionally been viewed as strengths or protective factors and processes in African American families. We must also be cognizant that the current state of our science limits our ability to systematically capture these Africentric values and socialization practices. A better science of African American children's early development will provide the most promising basis for addressing their mental health needs.

The Sociocultural Context of African American Infants' Development

Infant and toddler development in African American families, as in other families, is shaped by several ecological factors: parents' goals, values, and behaviors; parental work demands; parental mental health; family organization; family strengths; social support networks; and neighborhood contexts. A brief review of the literature (largely focused on

mother as parent) illustrates this point, as well as the need for more research.

Parenting goals, values, and behaviors

African American parents, like parents in any ethnic or cultural group, may share a unique system of values and practices that overlap, but differ in some ways from those of other cultures (Garcia Coll, 1990). With respect to infancy, for example, parents from different cultural groups may differ in their views concerning the fragility of newborns, their perceptions of and responses to crying, and the importance of encouraging specific developmental skills.

Unfortunately, researchers have conducted few comprehensive studies of the developmental goals, values, or caregiving practices of African American parents of infants (Rosser & Randolph, 1989). Researchers have long-claimed that it is inappropriate to use standards of parenting derived from the study of middle-class white families to evaluate the

functioning of minority, often low-income, parents and children (e.g., Levine, 1977; Ogbu, 1981). These researchers note that like other parents, minority parents attempt to foster behavioral competencies they feel children need to survive in their environment. For example, in a study of African American parenting in inner-city neighborhoods, Ogbu (1981) found that parents expressed abundant warmth in infancy, followed by an absence of warmth, inconsistent demands for obedience, and the use of physical discipline in the post-infancy period. Ogbu suggests that these

strategies promoted traits parents felt essential for child survival, including self-reliance, resourcefulness, mistrust of authority, and ability to fight back. The unconscionably large number of young African American children living in poor, single-parent families (Children's Defense Fund, 1998) and the special childrearing challenges of mothers within the context of welfare reform argue for the urgency of socioculturally specific research.

In order to understand the socialization goals and parenting strategies of African American families, it is critical to consider the sociocultural context in which they occur. Low-income African American mothers may live disproportionately in situations (e.g., poor housing, violent neighborhoods) that present challenges to parenting (Stevenson, 1994). Yet, despite these challenges, some parents succeed in raising healthy, competent children. However, our understanding of whether dimensions of parenting routinely identified in child development literature—such as warmth, nurturance, responsivity, and control—are expressed in culturally specific ways is limited by the fact that these variables are not well tapped by traditional measures.

Like other parents, minority parents attempt to foster behavioral competencies they feel children need to survive in their environment.



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Maternal work demands

Today, an increasing number of low-income African American mothers with histories of receiving public assistance are joining the workforce. Government programs such as Temporary Assistance to Needy Families (TANF) now have mandatory work requirements and lifetime limits. Many of the jobs available to low-income parents are stressful, unstable, and demand variable work hours (Center for the Future of Children, 1997). When work and family demands are in conflict, mothers may significantly reduce the time they have available to interact with their children (Howes et al., 1995). Moreover, demanding jobs may create psychological distress and dysfunctional parenting behaviors (McLoyd, 1990). Alternatively, the opportunity to work may provide parents with a sense of self-esteem and emotional reward, enhancing the mother's sense of competency in the childrearing role (Howes et al., 1995). Thus, it is important to understand the impact of new maternal work demands on infant/toddler development because work involvement has the potential to be linked with child outcomes.

Maternal mental health

Another key parental factor that may be related to effective parenting and child outcomes is the parent's mental health. Living in a low-income family and neighborhood may increase the probability of parents' emotional distress or depression because of exposure to negative situations/events (e.g., unpredictable income, neighborhood violence). Preoccupation with basic survival issues may reduce parents' physical energy, undermine their sense of competence, and diminish their sense of self-control (Halpern, 1993). When parents experience emotional distress or depression, they

may lose interest in activities previously experienced as rewarding, including caring for their children (Willner, 1985). Several studies have reported a relationship between psychological distress and reduced quality of parenting (e.g., Colletta, 1983; Simons, Beaman, Conger & Chao, 1993).

Previous research has found that low-income African American parents experiencing emotional or physical problems may provide inconsistent care of infants, pushing their children's needs into the background when they feel distressed. In an early study of Washington, D.C. parents in a public housing project, Jeffers (1967) found that parents experienced mood swings that contributed to discontinuity in the day-to-day care of infants. In another early study involving African American inner-city families in St. Louis (Rainwater, 1966), mothers were found to alternatively enjoy and ignore their children, as a function of other events/crises that were demanding their attention. In view of the recognized importance of nurturance, consistency, and maternal validation in optimal development, there is a need to conduct additional research exploring how the parent's mental health influences the developmental trajectories of poor African American infants.

Family organization

Researchers and mental health professionals acknowledge the critical role of families in infant development. However, researchers and practitioners may need to describe families in ways that include the dimensions of culture and ethnicity, relationships, and economic circumstances (See, for example, Phillips & Cabrera, 1996; Randolph, 1995) and also take into account family members' income, education, language, country of origin, degree of acculturation, and other sociocultural dimensions. The family contexts of African American infants and other infants of color may differ from those of the majority population in several ways, and these differences may influence infant development and family interaction with the mental health system. For example, low-income African American families tend to be characterized by younger mothers, a higher percentage of single mothers, and a greater likelihood that households will include family members other than biological parents and their children (kin residence) (Dickerson, 1995; Staples & Miranda, 1980; U. S. Bureau of the Census, 1995). Infants who are cared for by multiple members of a household may benefit from multiple secure attachments or may experience inconsistent parenting practices that jeopardize optimal development. In the context of the unpredictability of life that many poor families experience, the presence of multiple caregivers (kin residence) may protect children from risk – for example, parents' mental health problems that interfere with consistent, responsive caregiving (Halpern, 1993; Ornstein & Ornstein, 1985).

Consideration of the multigenerational configuration of many African American families, with its implications for childrearing responsibilities, may provide valuable guidance

about whom to involve in mental health treatment strategies (Traditional approaches assume that the mother is the principal caregiver) (Administration for Children, Youth and Families, 1996). Specifically, this knowledge may dictate which family members should be included in parent involvement activities and educational/clinical interventions to handle an infant's special needs. Although there have been numerous studies of African American family structure, research concerning the influence of family configuration on child rearing, parent-infant interaction, or developmental processes during childhood is scarce (Garcia Coll & Meyer, 1993; Jackson, 1995; Wilson, 1984). Studies of the sociocultural context of African American infant development need to explore who is parenting the infant and the impact of family configuration on infant mental health.

Family strengths

One way in which African culture manifests itself in contemporary African American life is through family strengths. Hill (1993, 1997) links several positive aspects of African American family functioning and child and adult development to African cultural legacies — the resilience of low-income children, the high achievement orientation of single parent families, the role flexibility of black female-headed families, the low levels of substance abuse among black youth, and the continuing positive influence of black extended families. We need to learn more about how and to what extent African American family strengths serve to promote and protect young children's healthy social and emotional development, possibly by buffering the stress of isolation and other adverse circumstances experienced by low-income mothers with infants and toddlers.

Social support

Informal social support has traditionally been recognized as critical to the well being of individuals in African American families (Hays & Mindel, 1973; Hill, 1993). Both relative and non-relative ("fictive") kin networks have played an especially important role in providing support for poor urban African American families (Billingsley, 1968; Stack, 1974). African American families are more likely to receive child care assistance from extended kin, to perceive extended kin as significant, and to live in close proximity to extended families or in multi-generational family households than white families (Hofferth, 1984; Jayakody, Chatters, & Taylor, 1993). The ability to form and maintain social networks can be crucial to a low-income mother's psychological well being and parental functioning (McLoyd, 1990).

Some cautions are in order here. Despite some studies

showing that social support networks provide parents with child care, assistance with household tasks, and opportunities to pursue educational or employment goals (Hogan, Hao, & Parish, 1990; Letiecq, Anderson, & Koblinsky, 1996), the relationship among social support, parental functioning and African American infant/toddler outcomes remains unclear. Indeed, members of social networks may introduce stress into families rather than protect against it (McAdoo, 1986; Randolph, 1997). For example, non-parental caregivers may be in conflict with parents about discipline or developmental expectations for children at certain ages. Non-parental caregivers may also view seeking mental health treatment as stigmatizing, and discourage parents from seeking help in the mental health service delivery system. Thus, before developing programs for families or individual plans for infants that rely on informal and formal supports, staff should explore whether the parents' social support networks operate as protective or risk factors for addressing mental health problems.

Neighborhood and community contexts

Neighborhoods have been defined as physically bounded areas characterized by some degree of relative homogeneity and/or social cohesion. Communities are often defined by the residents who live in them (as geographically bounded or being comprised of individuals who share some common characteristic). Recently, educators have stressed the importance of investigating neighborhood and community level variables that may affect parenting and child development. Potential variables for examination include the degree of neighborhood organization/disorganization, availability of resources, neighborhood norms and expectations for parenting and child development, and level of

community violence. A few previous studies have found relationships between the quality of parenting, the availability of neighborhood resources for childrearing (Garbarino & Sherman, 1980), the perceived danger in the community (Kriesberg, 1970), and the degree of neighborhood transience and the proportion of older adults in the community (Cortterell, 1986). The National Research Council/Institute of Medicine report, *From Neurons to Neighborhoods* (Shonkoff & Phillips, 2000), concluded: "The combination of family poverty and neighborhood poverty poses double risk to a substantial minority of black children and, to a lesser extent, to Hispanic children, who are much more likely than white children to grow up in these circumstances" (pp. 335-6). Many families of color, including those of African American heritage, experience different neighborhood or other residential environments than the majority population because of

Before developing programs for families or individual plans for infants that rely on informal and formal supports, staff should explore whether the parents' social support networks operate as protective or risk factors for addressing mental health problems.

their lower socioeconomic status. As a result, these families and their infants may encounter numerous problems associated with socioeconomic disadvantage, including substandard housing, seasonal migration, residential segregation, neighborhood disorganization, and high levels of community violence. Many minority neighborhoods are experiencing a loss or breakdown of the religious, social, and economic institutions that are vital to family life and provide potential routes out of poverty (Halpern, 1993). These neighborhood characteristics may contribute to survival-oriented patterns of parenting and relating to others (the "adaptive culture"), including isolation from family and friends; mistrust of neighbors (with whom parents formerly shared child care responsibilities); and restriction of infants and children from virtually all outdoor neighborhood play. Thus, neighborhood characteristics of low-income African American families may force parents to focus on particular dimensions of caregiving (e.g., physical care, child protection) at the expense of others (e.g., play, empathic responsiveness).

Alternatively, as suggested by the integrative model of development (Garcia Coll et al., 1996) "adaptive cultures" may develop in communities of color in response to the lack of growth-promoting environments for their children. Informal child care arrangements, fictive kinships, augmented family households (Billingsley, 1968), and home-based economies (in-home services, church-based family services) are examples of adaptive cultures. A better understanding of how these adaptive cultures respond to families' and children's needs, including mental health needs, could assist practitioners in developing more culturally anchored mental health services for African American infants/toddlers.

Application of a Framework To Improve Cultural Responsiveness to the Mental Health Needs of Infants of Color

A constantly evolving framework that has been widely used to develop more responsive mental health services for children of color is the cultural competence framework (Cross, Bazron, Dennis, & Isaacs, 1989). Cross and his colleagues define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or professionals to work effectively in cross cultural situations" (Cross et al., 1989, p. 13). In an attempt to operationalize this concept and apply it to developing systems of mental health services for children, Cross et al. (1989) identified five elements that characterize culturally competent organizations:

1. They value diversity (i.e., understand that other cultures may adhere to preferences for certain values, behaviors that differ from the dominant culture);
2. They have a system for cultural self-assessment that allows them to choose policies and practices that reduce barriers to participation for members of various

cultural groups;

3. They are aware of the dynamics that occur when persons from different cultures interact (e.g., differences in communication styles, help seeking behavior, or problem solving styles);
4. They institutionalize cultural knowledge (e.g., through provision of culturally appropriate services, cross-cultural training for staff, or establishing networks with community leaders and groups); and
5. They are able to adapt to diversity (e.g., adopt policies and procedures to reduce negative stereotypes and prejudices) (Hernandez, et al., 1998).

Cross et al. (1989) describe a six-point continuum of cultural competence, anchored at the low end by *cultural destructiveness* and at the advanced end by *advanced cultural competency or proficiency*.

- **Cultural destructiveness** includes attitudes, policies and practices designed to destroy another's culture (e.g., genocide, the holocaust, or in a lesser form, denial of access to natural helpers).
- **Cultural incapacity** applies to situations where the intent is not to destroy a culture, but the organization's capacity to be responsive is altogether missing. Practices are discriminatory, unintentionally racist, and manifest subtly through agency personnel's lower expectations for children and families of color.
- **Cultural blindness** applies to agencies that use approaches of the dominant culture because they believe that service approaches are universally applicable. These agencies are ethnocentric, lack information on how to provide culturally responsive services, and are not aware of how to obtain the information they need to be more responsive.
- **Cultural precompetence** applies to agencies that realize their limitations, and attempt to address them by hiring staff that reflect the community served, reaching out to the community, providing diversity training, and recruiting board members from the community. The danger is a false sense of accomplishment that these types of activities fulfill their commitment to cultural competency (Hernandez, et al., 1998). For example, hiring a person of color may not address the needs of the families; this person, too, may need training in that they have typically been trained in the approaches of the dominant culture.
- **Cultural competence** is characterized by the five elements identified above by Cross et al. (1989). These agencies' respect for the cultural integrity of families of color is reflected in service models, continually seeking advice, and the establishment of networks with formal and informal supports from the communities they serve (Hernandez, et al., 1998).
- **Advanced cultural competence or cultural proficiency** is evident when agencies hold families in high esteem, develop new or innovative approaches to

family service delivery through continuous quality improvement, disseminate lessons learned, and advocate effectively for families and children. Advanced competence or proficiency is reflected at every level from the board to the management staff to the "front-line workers"; in research and evaluation activities (e.g., participatory or empowerment models); and in pictures on the wall, magazines in waiting rooms, and policy manuals. Agencies and individual practitioners need to understand where they are along the continuum of cultural competence before attempting to develop or adapt programs to be more culturally responsive to the mental health needs of infants in families of color.

Implications for Practice, Research and Policy

Lessons from the past and limitations in our current knowledge base dictate that we mount a concerted effort to improve the current state of our practices, research and policies. The following suggestions are made to guide efforts directed toward generating culturally responsive programming in infant mental health.

Practice

Mental health professionals should be familiar with settings in which families of color encounter stressors. In assessing family well being, resources and needs, practitioners gather information from key members of the family who may also serve as "parental figures," family strengths, and the presence of traditional cultural values that may promote optimal child outcomes. Mental health practitioners should form partnerships with early childhood educators and administrators to improve screening and identification of children at risk.

A basic issue in investigating the impact of sociocultural context on development is the definition of developmental or socioemotional skills and problems in infancy (Garcia Coll & Meyer, 1993). Generally the normative standards by which child development specialists identify developmental strengths and problems reflect the dominant Anglo culture. The traditional use of parenting and infant measures normed on white middle-class families has resulted in the interpretation of differences as deficits, masked the strengths of many minority parents and children, and produced misguided intervention approaches (Garcia Coll & Meyer, 1993; Myers, Rana and Harris, 1979). For example, a child care provider or therapist may try to reduce an African American toddler's "overactive, aggressive" behaviors while a parent reinforces those same

behaviors because she or he feels they will protect the toddler in the violent neighborhood where they live. Practitioners should also consider the extent to which an infant or toddler's worrisome behavior or a parent's lack of response to suggested mental health treatment may be a reflection of parents' responses to their social situation—racism, discrimination, or other social injustices. Some African American psychologists have suggested using parents' life experiences with racism and racial socialization as tools in psychotherapy with African American children (e.g., Greene, 1992). The extent to which parents are concerned about racism and its influence on infants or the extent to which they begin racial socialization during infancy needs to be explored. Support groups or outreach strategies utilizing members of the community and messages that promote communalism could encourage mothers who are reluctant, due to cultural mistrust or perceived stigma, to seek needed mental health services.

Thus, to better serve African American and other

minority families, practitioners must not only seek to understand parents' views of their infants' behaviors and their own parenting needs, but must also address the challenges of the family's living environment. Devoting time to understanding important elements of the infant's sociocultural environment will enable practitioners to incorporate family and community strengths in intervention efforts and honor the cultural diversity of families (Bredekamp & Copple, 1997; Phillips & Crowell, 1994). Partnerships that include the mental health community, early childhood community and family will also broaden the resources available to address the mental health problems of infants of color.

Lessons from the past and limitations in our current knowledge base dictate that we mount a concerted effort to improve the current state of our practices, research and policies.

Research

Throughout this article we have emphasized the need for basic and applied research on the structures and processes that facilitate optimal development of infants/toddlers in African American families. These calls for additional research extend to families of other racial/ethnic backgrounds that have been understudied in the literature but who represent a growing segment of the U.S. population. Both the programmatic complexity that will be required to address the needs of these communities and the policy challenges that face policymakers in this arena will require science-based solutions. The basic conceptual approaches on which researchers have traditionally relied need to be expanded to incorporate the world views of the target populations and respect the cultural integrity of the communities to which this research, practice and policy will be directed. This conceptual shift or new ways of knowing will require the application of more integrative models such as

that offered by Garcia Coll et al. (1996), a research agenda that is more inclusive both in terms of populations and issues of cultural relevancy, and innovative methods for data collection and analysis.

Policy

Enhancing the resources of communities where families with infants and toddlers live must become a public policy priority. Part of this effort should involve strengthening the continuum of mental health services to ensure:

- adequate resources for training practitioners, providers, and parents;
- training for undergraduate and graduate students seeking to provide mental health services to families of color;
- enhanced screening and assessment procedures;
- participation of local mental health professionals in the mental health service delivery system for infants and toddlers; and
- cultural competence in community systems of care.

The Surgeon General's Reports on Mental Health and Children's Mental Health (2000, 2001) and the Healthy People 2010 Objectives articulate the need to change our view of the mental health needs of an increasingly diverse population of children and families, and offer goals to strive toward. The Head Start Program Performance Standards for mental health (1996) provide guidelines useful not only to Head Start but to any community efforts serving families with young children. By working together, across disciplines, across settings, and yes, across cultures, we can use our science-based knowledge and the wisdom of practitioners and families to ensure healthy development for all children.

"Spider webs united can tie up a lion!" African proverb

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IS MOM'S MIND ON HER BABY?

Infant Mental Health in Early Head Start



PHOTO: MARILYN NOELT

Can I trust you?"
"Will you keep me safe?"
"Will you be there for me?"
"Can you take care of me?"
If they could speak, these are the questions babies might ask as they leave the womb and enter the arms of their mothers and fathers. Babies come into this world completely dependent on their caregivers—for safety and protection, for food and physical care, and for love and nurturance. For babies to flourish—indeed, even to survive—they need loving human interaction and stimulation as much as physical care. They need mothers and fathers who can say "Yes!" to their newborn's first question, and "I'll try my best" to the others.¹

Children develop in the context of relationships. The Advisory Committee on Services for Families with Infants and Toddlers, summarizing more than three decades of

¹ Much of the content of this article comes from a research partnership between the authors and a local Early Head Start Program. JoAnne Solchany also consults with several other Early Head Start Programs and 0-3 Intervention Programs. Kathryn Barnard was a member of the Advisory Committee on Services for Families with Infants and Toddlers. An adaptation of this article will appear as a chapter in the forthcoming book, *Early Head Start: Beacon of Hope for America's Youngest Children*, edited by Joan Lombardi and Mary Bogle, to be published by ZERO TO THREE.

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research in its 1994 Statement, which provided the rationale for Early Head Start, noted:

The child-caregiver relationships with the mother, father, grandparent and other caregivers are critical for providing infants and toddlers support, engagement, continuity and emotional nourishment necessary for healthy development, and the development of healthy attachments. Within the context of caregiving relationships, the infant builds a sense of what is expected, what feels right in the world, as well as skills and incentives for social turn-taking, reciprocity and cooperation (Advisory Committee, 1994, p. 7).

Similarly, the Committee on Integrating the Science of Early Childhood Development of the National Research Council/Institute of Medicine concluded, in its 2000 report, *From Neurons to Neighborhoods*:

A vast store of research...has confirmed that what young children learn, how they react to the events and people around them, and what they expect from themselves and others are deeply affected by their relationships with parents, the behavior of parents, and the environment of the home in which they live (National

Research Council/Institute of Medicine, 2000 p. 226).

For babies and toddlers, the relationship with their primary caregiver – usually the mother – plays an especially significant role in their mental well being. This is why a mother's ability to truly attend to her baby (rather than on her own troubled past or present) is such a powerful indicator of strength or fragility in a child's caregiving environment. A mother who can put her child's needs before her own needs is able to provide the nurturance that a child needs to establish a healthy sense of well being. As the baby enters the mother's arms, that baby should also move to the forefront of the mother's mind. It is why we ask, "Is Mom's mind on her baby?"

In this article, we will look at infant mental health from a relationship perspective. We will describe, in some detail, patterns of interaction between babies and their mothers; these interactions, repeated over time, create unique relationships. We will also discuss how adult relationships in Early Head Start – between staff members and parents, and between home visitors and their supervisors – can protect and strengthen mother-baby relationships. In addressing these issues, we will refer to the growing body of clinical and scholarly research on infant mental health that underlies sound program design and practice in Early Head Start and other infant/family programs. We will also share stories and case examples (with identifying details changed) of women, babies, and program staff from Early Head Start programs and other community-based intervention programs serving infants, toddlers, and their families. These stories demonstrate many of the challenges as well as the successes found throughout these programs. Finally, we will continue to return to the question, "Is Mom's mind on her baby?" for it is the answer to this question that often determines the answer to the baby's question: "Can I trust you?"

Two Patterns of Interaction

The stories of Paula and her daughter Haley, and of Sylvia and her son Rocko, show how different patterns of interaction develop and come to characterize mother-child relationships, and how babies' development proceeds within these relationships. Both mothers were pregnant and single when they enrolled in an Early Head Start program that offered weekly home visits and group "socializations" twice a month. Each mother worked with a single home visitor during her pregnancy and her baby's first year.

Paula and Haley

Paula was 26 years old when she enrolled in Early Head Start. Her son Billy was three years old, and she was preg-

A mother who can put her child's needs before her own needs is able to provide the nurturance that a child requires to establish a healthy sense of well-being.

nant. On her first visit to Paula's home, the home visitor observed that Paula seemed sad. She wore oversized men's clothing that was frayed and torn in places. Her apparently unwashed hair hung loose; when it fell across her face, Paula didn't push it aside. Paula's apartment was cluttered and messy, strewn with empty fast food bags and wrappers. Three-year-old Billy was equally disheveled, with long tangled hair. During the visit, he was frequently "out of control" – throwing toys, screaming, hitting, and banging his head on the walls. Paula's affect never seemed to change: She did not

smile at Billy, set limits for him, or intervene with his behavior; she reacted slowly to questions and spoke only in a low, quiet, whiney voice.

Paula delivered a healthy, eight-pound baby girl whom she named Haley. Once home, Paula would feed and change Haley but did not speak or otherwise interact with her. She responded only slowly to Haley's cries and then offered a pacifier. During the first three months, Haley was alert and interactive, and seemed to want to connect with her mother. Haley also responded well to Gretchen, the home visitor. Paula seemed unable to accept Haley's bids for her attention; she continued to ignore Billy as well. Paula continued to face her own challenges; she herself ate little and reported that she "never slept" – although she would nod off during visits.

Paul avoided contact with any adults other than Gretchen. Even with Gretchen, Paula interacted minimally. She would only let her in at the appointed time for her visit, respond minimally to questions, accept and sign paperwork, and schedule future appointments. She neither interfered nor interacted with child development opportunities. Gretchen worked hard to engage Paula with each visit. When Paula would not engage, Gretchen would interact and work directly with Haley. She left information about parenting courses, invitations to socializations and activities, and even made attempts to model limit setting and positive reinforcement of Billy.

Amazingly, for the first six months of her life, Haley

at a glance

- Looking at infant mental health from a relationship perspective means asking, "Is Mom's mind on her baby?"
- Home visitor/parent relationships in Early Head Start and other infant/family programs can protect and strengthen mother-baby relationships.
- Parent-Child Communication Coaching (P-CCC) is anchored in specific scientifically grounded activities that home visitors can implement from pregnancy through the first 30 months.
- Multi-level interdisciplinary approaches are often needed when families face multiple risks to children's and parents' mental health.

stayed in the 75th percentile on growth charts for height and weight and achieved developmental milestones on schedule. Then Gretchen became aware of changes in Haley. She would avert her gaze when Gretchen approached. She rarely cried, and when she did, her cry was muted; to Gretchen the cry sounded futile, as if Haley expected no response. Haley's movements became slow and apparently aimless—not like the intentional actions one would expect to see in a baby her age. Gretchen received no support from the medical provider for her concerns. She made several mental health referrals for Paula, which Paula refused. She made several Child Protective Service reports, citing neglect, but received little support; no actions were ever taken by Protective Services. Gretchen also made attempts to get both children into child care, which Paula also refused.

By 12 months, Haley seemed to have stopped actively exploring her environment. She would lie on her back most of the time, although she occasionally sat up or reached for a toy or object that may have been lying close to her. She watched people around her but averted her gaze when anyone looked at her directly. Occasionally, Haley would pick up a toy that Billy had dropped, but would do little more than lift it up, examine it briefly, and let it fall back down by her side. She had fallen to the 25th percentile for height and weight but was still being assessed by her medical provider as physically healthy.

Sylvia and Rocko

Sylvia was 24 years old, single, and pregnant with her first baby when she enrolled in Early Head Start. Her apartment, though sparsely furnished, was quiet, clean and organized; she was gradually accumulating a stock of baby toys and equipment. During her pregnancy, Sylvia would invite Gretchen to sit with her at her clean, uncluttered kitchen table; she eagerly examined the materials about pregnancy, childbirth, and child development that Gretchen brought.

Rocko was born a healthy, eight-pound, 6-ounce baby with no difficulties. He was quiet, seeming to cry only when hungry—often not even coming to a full cry as Sylvia responded quickly to his little fusses, groans, and grunts. When Gretchen came to visit, Sylvia always had Rocko in her arms, either sitting on the sofa or in a rocking chair. As she talked with Gretchen, Sylvia would intermittently speak to Rocko in a cooing voice, asking him if he was hungry or telling him she loved him.

Rocko grew steadily and had no medical problems. By six months of age he was bright, alert and interactive. He would frequently burst into laughter over a playful look from his mother or Gretchen. By 12 months of age he was walking, playing with toys on his own for short periods of time, following his mother around the apartment, and dancing to children's music she played regularly on the stereo.

As different as Paula and Sylvia, and Haley and Rocko, are from each other, their circumstances are equally common in Early Head Start and other community-based programs serving families with infants and toddlers. Indeed, on an enrollment form for a service program, Paula and Sylvia

might look almost identical—single mothers in their twenties, both high school graduates, receiving public assistance, and living in a low-income neighborhood with few sources of informal social support. But what about the feelings and connections between these mothers and their babies? For Paula, trying to take care of each of her children, as well as herself, is a struggle. She manages to provide basic food and shelter, but she seems unable to provide the nurturance, protection, and stimulation that her children should be able to count on. Paula's mind does not seem to be on her baby. Sylvia, in contrast, thinks about and plans for Rocko even before he is born. She responds to her baby quickly, easily, and creatively, providing Rocko with the nurturance he needs to grow and develop into a healthy, interactive, happy toddler.

The stories of Paula and Haley and of Sylvia and Rocko suggest the ways in which babies' development reflects the mothering they receive; this is a large component of infant mental health. Both Haley and Rocko were born healthy and robust. But within six months, Haley has become lethargic and is beginning to avoid—rather than seek—human interaction. By 12 months, her social, physical, and emotional development are causes for concern to a knowledgeable observer; closer examination would likely reveal cognitive delays as well. Haley demonstrated dysfunction in her mental health status. Rocko, on the other hand, shows pleasure in interaction, seeks it out, is physically active, and shows a range of emotion from his first days onward. He is solidly connected to his mother and responds joyfully to the emotional warmth and richness of experience she offers. Rocko demonstrates a baby functioning with more optimal mental health.

Home visitors like Gretchen—as well as child care providers, primary health care workers, and other community-based infant/family practitioners—must constantly consider how best to support positive parent-infant relationships (like that of Sylvia and Rocko) and strengthen or repair worrisome relationships (like that of Paula and Haley). What can we do to prevent the development of mental health problems? What can we do to intervene when we identify the potential for development of infant mental health problems? How do we handle a problem that is already present? Infant mental health practice encompasses a continuum of activities and services designed to respond to these questions. Several ways to approach infant mental health have been used. These programs can be viewed in terms of their focus—parent-based, focused on the teaching of parenting and caregiving skills; child-based—working directly with the child on developmental issues; and relationship-based, which involves working within the context of the relationship. Fonagy (1998) describes a multi-level approach that includes *early parent training, enhancement of the attachment security system, and supporting the development of the reflective function within the relationship*, with each level having significant effects on the early parent-child relation-

ships. He effectively argues that these types of early preventative interventions can break the vicious cycle of parent-child interactions that often lead to childhood psychological disorders and other pathologies.

Envisioning and Encouraging Caregiving Behaviors That Promote Mental Health

We will describe a program approach we have developed and used in an Early Head Start program, the Parent-Child Communication Program (P-CCC). This program focuses on mental health promotion and prevention from pregnancy through the first three years. It involves "coaching" the parent-child relationship and interaction through the use of specific activities and videotape intervention.

Parent-Child Communication Coaching

In the context of our efforts to help staff of Early Head Start and other community-based programs enhance parent-child interaction and parent-child attachment as well as optimal mental health, we identified caregiving behaviors during pregnancy and four periods of early development that we believe, based on child development literature and our experience, promote positive interaction between parent and child and thereby promote mental health for both. We then designed an intervention approach, P-CCC, that was anchored in specific, developmentally appropriate and scientifically grounded activities that would appeal to participants and that home visitors could be expected to implement during each period of development.

Pregnancy

It is desirable that the pregnant woman be aware of the physical presence of her unborn child. Acknowledgment that a child is growing inside her womb is the beginning of a life-long connection a mother will establish with her child (even if the child does not survive or if others raise the child). Acknowledging the unborn child is, however, only the beginning of the psychological work of pregnancy; the woman must also begin to imagine what the baby will be like and what becoming a mother will require of her. These maternal behaviors significantly affect the relationship she will establish with her child after birth. If a mother has difficulty connecting with her baby before birth, she is highly likely to continue to experience difficulties within her relationship—in other words, she will have a difficult time keeping the baby "on her mind."

Other issues also come into play during pregnancy that may relate to the development of the mother-child relationship. For example, the type and amount of support available to the woman during her pregnancy has a significant impact on the mother's capacity to relate to her baby. A woman with no or little support becomes at high risk for difficulties transitioning into motherhood and in relating to her child

(Rubin, 1975; Solchany, 2001). Among the mothers in our Early Head Start study, fewer than 3 in 10 said they had a supportive partner or husband during their pregnancy.

Some of the behaviors we hope to see in women during their pregnancy and the supports we believe are important to them and their unborn children include:

- Being aware of the presence and activity of their unborn child
- Having emotional support
- Imagining or fantasizing about motherhood and the baby
- Beginning some type of communication (like singing) with the unborn child
- Feeling connected or bonded to the child before birth
- Making plans and/or preparing for the birth and arrival of the baby.

In the P-CCC² approach, the home visitor encourages the mother to keep track of the baby's "kicks and wiggles" in the second and third trimester of pregnancy and to think about the baby's activities in relation to her own activity. Exploring present support systems, strengthening them, and filling in any gaps is also a major task during this period. Another important goal is to help the mother to lay the foundation for attachment through activities focused on connecting with the unborn child.

Birth through Three Months

In the first three months after birth both the mother and baby must make significant transitions. The baby must adjust to living outside the womb and establishing feeding and sleep rhythms that provide a foundation for physical, cognitive, and social-emotional growth and development. The mother has to begin to think of herself as a mother and must put the baby foremost in her mind. She must learn how to recognize, understand, and meet the baby's demands as well as find a balance and synchrony in her relationship with her baby. Keeping the baby close at hand is a behavior that seems to be good for both parent and child in this period. In addition, other important maternal behaviors during this period include finding ways to connect with baby (eye contact, games), getting comfortable with the role of a mother, and understanding babies' capacities for experiencing and expressing emotion. In our community of mothers, we found that almost half found it hard to take care of their babies (46 percent). More than three out of five (61 percent) found motherhood to be different than they imagined. Tragically, 20 percent of women felt their new babies had the ability and motivation to become angry with them—which often leads to feelings of rejection and inadequacy on the mother's part.

Mothers' behaviors and attitudes that we believe promote healthy social and emotional development—or opti-

² The pregnancy activities used in this program, plus an additional 53 activities, have been published as: *Promoting Maternal Mental Health During Pregnancy: Theory, Assessment, and Intervention* (Solchany, 2001).

mal mental health—of babies during the first three months of life include:

- Understanding the baby's patterns and transitions (e.g., stages of sleep)
- Understanding the baby's behaviors, actions, and emotions
- Developing healthy and fun interactive times with baby
- Being close to baby (e.g., holding the baby during feedings, making eye contact, using a soft baby carrier)
- Being able to adapt to the unexpected parts of motherhood
- Having a support system that is readily available.

In the P-CCC approach, home visitors focused on supporting the mother's use of a soft baby sling. They also used a variety of materials and strategies to help parents learn about their babies and use what they learned in daily routines, such as feeding. The content from *Keys to Caregiving* (NCAST, 1990) provided the framework for helping the parents understand their infant's cues and behavior.

Four to Eight Months

During this period, babies become experts in social responsiveness. They typically love to play social games, make eye contact, and often burst out in smiles when they find a partner who is fun to be with. During this period, babies begin to develop the capacity to experience a wide range of emotions and ways to express and communicate them; however, they still need their parents to help them modify and regulate those emotions. Babies who receive soothing and comfort when distressed begin to learn how to manage difficult feelings, whereas babies who receive no support can become overwhelmed and despondent around difficult emotions. Parents need to also be able to handle their own emotions in a healthy way if they are to be able to assist their babies effectively.

Babies also become powerful communicators at this age—so the goal for parents becomes being able to interpret babies' communications accurately and to respond sensitively to the baby's emotional needs of the moment. Each time the parent is able to respond appropriately to the baby their connection strengthens—the parent feels more satisfied that he or she can meet the baby's needs and the baby feels more and more secure that his/her parent(s) can be there for him/her and can be trusted.

When a mother's mind is on her four-to-eight-month-old baby, she is often anticipating the fun of interacting with her baby at this age. We have identified these abilities and behaviors in mothers that contribute to mental health:

- Understanding the baby's developing ability to express a range of emotions
- Understanding the baby's attempts to communicate and connect
- Understanding the impact of experiences and environment on the baby
- Keeping the baby close through use of a soft baby car-



PHOTO: MARILYN NGUYEN

rier, sling, or backpack

- Allowing/supporting opportunities for the baby to succeed in independent activities (playing with toys, falling asleep on his/her own, beginning self-feeding).

P-CCC activities at this stage encourage self-exploration of feelings related to mothering and the baby, and on the baby's emerging range and expression of different emotions, as well as on communicating and connecting with the baby through interaction based on imitation.

Nine through 18 Months

During the last part of the first year, children begin to spontaneously use gestures for communicating—for example, waving "bye-bye." The child's ability to communicate, along with the parents' attempts to understand the child, become important benchmarks of mental health within the parent-child relationship. Ideally, parents actively help the child develop non-verbal and verbal expression and respond to the child's words and questions, reinforcing attempts to communicate. A child who is responded to and encouraged to communicate is one who feels powerful in the world and significant in his or her parent's life. Children who are not spoken to or interacted with will often develop delays in the ability to communicate, leading to decreased interactions, impaired ability to communicate their needs clearly, and difficulty in being social or relating to others—dysfunctional mental health.

In our program, parents were encouraged to try and understand their baby's unique style of communicating wants, needs, and emotions—that is, the baby's gestures, sounds, and words. Parents often found that when they began to understand their baby's signs or gestures, conflict naturally lessened and both parent and baby enjoyed interactions more. Parents were next asked to teach the baby specific signs/gestures to increase their developing communication abilities. Having a sign for "poopy diaper" or a gesture for "I want to sit on your lap" simply made things easier for both parent and baby. The parenting behaviors we found most significant include:

- Increased understanding of the baby's attempts to communicate wants, needs, thoughts, and emotions (gestures, signs, sounds, and words)
- Interaction with the child using the child's signs or gestures
- Reading with the child.

The P-CCC approach, at this stage, focuses on helping parents to identify the child's own emerging way of using signs and gestures to communicate as well as teaching the baby specific signs and gestures to fill communication needs. As the child approaches the age of 15 months a greater emphasis is placed on developing the relational behaviors needed for reading. For example, we found that many of our parents had difficulty just "sitting" with their babies—a behavior necessary for reading activities. Therefore, home visitors worked with the parents using other "sitting with" activities such as toy making and interactive games. This preparation helped parents to be more ready for the use of reading to enhance the parent-child relationship during the last stage of early development we targeted.

Eighteen to 30 months

Talking, talking, talking. Reading, reading, reading. As a child grows and his/her social world expands, the ability to communicate with others takes on an even greater focus. Toddlers and preschoolers begin to rely on a larger vocabulary and an increased ability to use these words to communicate concepts and to question the workings of the world. Words and language help children to make sense of their world and also give them the tools to be able to understand their emotions and thoughts on a deeper level. A child who can say to an adult "I'm hungry" or "I am mad that Kimmy took my doll" is generally able to interact on a more positive level than the child who "falls apart" when hungry or hits or bites when angry over a typical peer conflict. A child with good communication skills has the tools to interact with others and to express him/herself—both significant pieces of infant mental health status. Reading is one of the most effective ways to provide children with these important skills and abilities. Reading with a parent provides shared interaction, shared attention, attentional focus to an activity, patience, anticipation, expression of emotion, practice in emotional regulation, body contact, nurturance, cooperation,

and joy. In addition, conversation with adults and reading to young children has been shown to support language development and cognitive development—both also foundational to the child's future reading ability. The behaviors we found supportive during this period are the same as with the period of 9-18 months.

Using videotaping in interaction guidance

Another component of the P-CCC program is interaction guidance. Many families who are participants in Early Head Start and other community-based programs may benefit greatly from interaction guidance. Interaction guidance can be described as a combination of education and coaching, teaching the parent how to interact in more productive and positive ways with the infant and then supporting and coaching the parent in interactions with the child.

Home visitors in community-based programs can learn to use interaction guidance, including the use of videotaping in the home. The practitioner uses the video with the parent as a point of departure for identification and reinforcement of the parent's strengths in nurturing the child. The practitioner and parent can also use the tape to observe and think about the child's responses and bids for connection. With the proper support, the parent may also examine what he or she might have done differently in certain instances. The video allows the parent to observe their own behavior and the infant-parent interaction from a different vantage point—that of an outside observer.

Videotaping within a community-based program can be a vehicle for building practitioners' skills in understanding a developing mother-child relationship and facilitating well-focused interventions. The following vignette illustrates how one home visitor benefited from the experience of videotaping and how those benefits were in turn passed onto the mother with whom she was working.

Kara, an Early Head Start home visitor, came to her five-member group supervision session with a videotape of 20-year-old Jennifer feeding her 18-month-old son, Rory. Kara had always regarded Jennifer very highly and often described her as "one of the best" mothers in the program. Even as she was present for the interaction and taping it Kara felt positive and excited at the prospect of talking to her colleagues and supervisor about this mom and baby. But as Kara told the group, when she reviewed the tape on her own she was surprised by worrisome aspects of the interaction between Jennifer and Rory—things she had never noticed before.

Jennifer could not seem to read Rory's signals that he was full; she forced food into his mouth regardless of what he did. Interestingly, she did this with a very loving and concerned voice and way of being: As Jennifer force-fed Rory, she simultaneously talked to Kara about how her son loves his food and loves to eat. Before presenting each spoonful of food, Jennifer banged loudly on the high-chair tray with the spoon, presumably to orient the child to the food. However, Rory seemed to startle in response to the noise. Interestingly, Kara had not noticed the

hanging at all until she viewed the video. She suggested it was because there were several other people in the home and the noise level was fairly high anyway.

Watching the video with Kara was a learning experience for everyone in the group. The video revealed a mother who seemed "under pressure." She was tense, and her interactions with her baby were tense and pressured. Her kind demeanor and positive, cheerful tone masked the underlying tension. The difficulty in the interaction was not easy to identify until we were all able to step back and observe. Once we were able to recognize the level of tension and misunderstanding in the feeding situation, we could see this pattern in some of the other interactions between mother and child. Kara was able to use the video with Jennifer to show her how Rory seemed to want more time to explore his meal, as well as slower, more thoughtful interaction with her.

Four months later, Kara brought the supervision group a new video. This showed a much calmer interaction between Jennifer and Rory. Mother and child interacted with words and gestures. Rory's pattern of response had shifted, as well. He now easily ate his meal, remained focused, and was able to laugh and enjoy his mother.

Video can be a powerful tool for helping mothers "get their minds on their babies" and for staff development in programs serving families with infants and toddlers. It can also help the mother to "step outside" of herself and own needs, allowing her to see things from the baby's point of view or even an observer's point of view. New points of view are among necessary first steps to making change within a relationship.

More Intensive Intervention

As the portraits of Paula, Sylvia, and their children at the beginning of this article suggest, many individual risk factors—and, more importantly, perhaps, the cumulative impact of multiple risks facing a child and family—may contribute to problems in infant mental health. However, a disturbed relationship between the primary caregiver and the child has been identified as one of the most significant risk factors, and one of the pathways most amenable to intervention. Several recent studies lend support to this view (Delcarmen-Wiggins & Carter, 2001; Carter, Garrity-Rokous, Chazan-Cohen, Little, & Briggs-Gowan, 2001; Keren, Fledman, & Tyano, 2001; Pawl & Lieberman, 1997; Reznick & Schwartz, 2001; Shaw, Owens, Giovannelli, & Winslow, 2001; Spieker, Solchany, McKenna, DeKlyen, & Barnard, 1999; Thomas & Guskin, 2001; ZERO TO THREE, 1994). In addition to relational risk factors, Keren, et al. (2001) found parental psychopathology to be a leading risk factor in the development of infant mental health problems.

Maternal depression has been identified as a major factor leading to infant mental health problems. However, in our work with many mothers in early intervention programs, we have seen mothers with depression provide a range of caregiving experiences to their young children, and varying developmental outcomes among these children. While we do not yet understand all the mechanisms at work, we know

that depression can be expressed differently in each person, that individual life circumstances are important to consider, and that many women who are diagnosed with depression may have additional, sometimes unidentified psychopathology that may worsen the experience for them (See Carter, Garrity-Rokous, Chazan-Cohen, Little, & Briggs-Gowan, 2001). Sometimes, working with a family around infant mental health issues involves a multi-level, interdisciplinary approach. Home visitors can help coordinate the meeting of the immediate needs of the family, they can steadily work with the baby or child with the goal of keeping development on track, and they can serve as a source of support for the mother and other family members. When the mother is facing major mental health issues herself, she may need intervention outside the realm of any single program or individual home visitor. Referrals to persons or programs specializing in treating depression and other mental health disorders are important. Developmental needs of the child may require referral to centers treating developmental delays. For the mother who cannot seem to connect with mental health services for herself or her child, a therapeutic day care or child development center where the child is in the care of others for a portion of each day or week may provide support to the child and parent. Out-of-home care may also provide alternative avenues to support and enhance the child's developmental progress. Respite care may also be helpful. Despite our best efforts, some families have difficulty accepting and using the services and assistance we offer—leaving us with the role of lending support and encouragement. In this section we describe the paths of two mothers and their children who were impacted by maternal depression. The stories of Marla, Erin, and their children illustrate the variability in mothers' and children's experience and the need for individualized intervention approaches.

Marla, Philip, and Lisa

Marla was the mother of Philip, age 30 months, and Lisa, age 14 months. Each child was delayed in several domains of development. Marla had a long history of homelessness, disconnection with her family, and a pattern of depression. Her personal hygiene was extremely poor. Her home was cluttered with fast-food bags; food was smeared on the walls and floor; and soiled diapers and half-full bottles were scattered throughout the small apartment she had only recently acquired. Marla seemed unable to interact with her children. She seemed frozen in one particular easy chair, focused on the TV. The Early Head Start home visitor would often find Marla in her pajamas, her children strapped into their high chairs, and the television on, regardless of the time of day. Marla seemed oblivious to what was going on with her children. At 30 months, Philip abused himself by biting himself and hitting his head on walls. He was often aggressive in his interactions with people—spitting at them or kicking them in the legs. He seemed to have no concept of "another child" when in potential play situations, and would engage with toys only fleetingly, soon disengaging by

throwing or beating the toy. Lisa, 14 months old, seemed essentially "empty." She made only fleeting eye contact, demonstrated signs of tactile defensiveness (splaying her fingers, refusing to touch things, unable to grasp certain objects), and seemed emotionally flat or empty, with no sense of joy.

Erin and Katie

Erin, mother of five, had been diagnosed and treated for depression several times before she became involved in Early Head Start. Erin's youngest child, Katie, when first born had a great deal of difficulty breastfeeding, which was extremely important to Erin. Her struggle to breastfeed her daughter quickly led Erin into another bout with depression. Erin was not able to sleep—she lay awake worrying and ruminating all night—mostly about Katie's not being as close to her as her other children because of the breastfeeding problems. Erin's appetite nearly vanished; she seemed unable to take care of herself, rarely washing her hair; she stopped cleaning her home.

Yet despite the problems Erin was experiencing, Katie was thriving. So were Erin's other children. Erin seemed to use all of her available energy to care for her children. They were clean, well fed, involved in school activities, and actively engaged in mental health treatment around issues related to the domestic violence they had witnessed between Erin and their biological father. In observing their interactions, the home visitor noted that Erin seemed to be able to "pull it together" for her baby. Her interactions were loving, nurturing, gentle, and focused. She talked frequently to Katie, describing what was happening within their interaction ("Mommy's going to change your diaper now..."), as well as describing her daughter's emotions ("What are these tears about Katie, are you sad? Did you miss Mommy?").

As these stories suggest, maternal depression can be experienced in very different ways—by mothers, and by their young children. Mothers who are facing multiple challenges typically need individualized, multi-layered interventions so that they can successfully nurture their infants and toddlers. When progress is slow, children need support to protect their developmental progress. Marla and Erin, described earlier, illustrate this point. For Marla, intervention consisted of getting her children into a full-time, therapeutic child care setting, getting periodic respite care, and providing in-home physical and occupational therapy for the children. Marla was offered counseling and was encouraged to begin a course of anti-depressant medication, but refused both. She did accept a home aide, who helped her set up a cleaner home and a regular schedule for the family. The children improved greatly, even though Marla remained "stuck."

Intervention for Erin initially involved twice-weekly

respite care for her children so that she could begin therapy. Erin was not initially comfortable with leaving her children with someone else—even for two-hour blocks—but agreed to try it for two months. She began psychotherapy and was also placed on medications. Several weeks later Erin told her home visitor that she "didn't know people could feel this good." Her energy increased, her interactions with friends and other adults increased, and she joined the parent council of her Early Head Start program. Keeping her home clean was still a struggle, but all of her children were doing well. Katie seemed well connected with her mother.

To work effectively with Marla, Erin, and their children, the home visitor needed to be aware of parent-based and child-based intervention approaches, to mobilize a wide range of community services as needed, and to use her own positive relationship with the mothers as the context within which all interventions occurred. She needed to find a match between the strengths and needs she observed in the families, the resources that were available in the community, and the readiness of the mothers to avail themselves of services.

The essence of infant mental health work lies within the parent-child relationship.

Summary

Infant mental health is emerging as a central focus of preventive and early intervention programs for children in the zero-to-three years. The essence of the work lies within the parent-child relationship. The baby needs to develop trust with the primary caregiver. He or she needs to feel confident enough to explore the world, and safe and secure as a part of the world. To provide security for a baby, the parent must see the baby as a priority—the baby's needs should

come first. This only happens when the parent can keep the baby in mind throughout the daily routines of life.

As a baby often responds as a whole person to a stimulus, rather than with just an eye blink, attention to infant mental health is best thought of as an integral part of Early Head Start and other comprehensive community programs, rather than as individual referrals to outside agencies or providers. To promote and protect infant mental health, Early Head Start and other community program staff will need to be able to recognize what a mentally healthy relationship between a parent and an infant looks like, observe and assess the relationships between parents and young children, and work with parents to strengthen or repair their relationships with their babies and toddlers. This will happen during moment-by-moment opportunities for creating attunements in the relationship in feeding, play and caregiving. Child care staff, home visitors, and family advocates can work in concert with mental health professionals as co-architects of the infant mental health component of Early Head Start and other

community programs.

It is important to remember that, given the mental health challenges families face, the paucity of resources available in the community, and prevailing attitudes about infant mental health, it is often a major accomplishment for a home visitor to maintain her connection with a mother through continuing home visits. The home visitors described in the vignettes in this article were among the best we have worked with. They tried diligently to understand each family on their caseload, made necessary referrals, and remained dedicated to the well being of the children and the parents. But they faced enormous obstacles to effective practice, including: lack of response from Child Protective Services to reports of neglect; lack of knowledge and/or reluctance of medical providers to identify or diagnose infant mental health issues; lack of community resources to address identified infant and/or maternal mental health needs; program cultures that emphasize keeping mothers or families enrolled, sometimes leading to staff reluctance to raise difficult issues; and societal unwillingness to acknowledge infant mental health problems (see Emde and Zeanah, this issue) and support community-wide responsibility for young children's mental health.

We have tried to suggest in this article the many ways that staff of Early Head Start and other community-based programs can protect and strengthen mother-baby relationships, making it easier – or possible – for mothers to keep their minds on their babies, and for babies to be able to trust in the care their mothers and other loving adults provide. Yet we are aware that — partly because space limitations prevent us from describing the entire course of intervention with each family — readers may experience a sense of missed opportunities for effective intervention. We encourage discussion of the work we have described and the often uneasy thoughts and uncomfortable feelings it may evoke. Only then are we likely to find the strength to demand necessary changes throughout the currently fragmented system of services for vulnerable families with infants and toddlers. ♦

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MOTHERS, BABIES, AND DEPRESSION:

Questions and Answers

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Q: There seems to be growing concern about "maternal depression" as a serious mental health problem for women and a risk factor for children's development. What is maternal depression?

A: "Maternal depression" is not a diagnosis or even a set of symptoms, but, rather, a term that is used to describe a spectrum of conditions that have varying consequences for the woman's own mental health, her functioning as a mother, her family's functioning, and her children's development. We have learned that it is not uncommon for mothers to experience depression soon after childbirth and during the first year of their baby's life.

- An estimated 50-80 percent of all mothers experience *postpartum blues* in the first 10 days after childbirth. Symptoms may include tearfulness, fatigue, insomnia, and feelings of loss or being overwhelmed.
- Approximately 8-15 percent of women experience *postpartum depression* sometime during the first year after childbirth. Postpartum depression is a major depressive episode, with symptoms – lasting two weeks or more – commonly including low mood, irritability, sleep and appetite disturbance, fatigue, loss of interest or the ability to feel pleasure in daily life, guilt, decreased concentration, indecisiveness, feelings

of worthlessness, despair, or thoughts about harming oneself or one's child. Postpartum depression will not completely go away without treatment; it may last for a period of weeks or for longer than a year.

- One in 1000 women, at most, may experience *postpartum psychosis* during the first year after childbirth, with most cases occurring before the baby is three months old. Symptoms include agitation, racing thoughts, rapid speech, hallucinations, paranoia, an inability to care for oneself or the baby, and thoughts about suicide or infanticide.

Currently, clinicians and researchers are placing "maternal depression" in a larger context. For example, a just-pub-

at a glance

- It is not uncommon for mothers to experience depression soon after childbirth and during the first year of their baby's life.
- Early identification and treatment of maternal depression is important for both mother and child.
- Community programs can help families affected by maternal depression through outreach to expectant and new mothers; emotional and practical support for mothers, children, husbands, and partners; use of standardized screening tools for depression; and offering empirically validated interventions for postpartum depression.

lished prospective study of 14,000 women in the United Kingdom found that rates of depression were higher during pregnancy than after childbirth (Evans, Heron, Francomb, Oke, & Golding, 2001). In the United States, researchers have been investigating the impact on women and their children of: the length (chronicity) of mothers' depression; the extent to which mothers experience other mental health problems in addition to depression (Carter, Garrity-Rokous, Chazan-Cohen, Little, & Briggs-Gowan, 2001); and living in adverse circumstances (Lennon, Blome, & English, 2001).

Q: How does maternal depression affect babies and toddlers?

A: It can be useful to think of maternal depression as part of a context for child rearing. The fact that a mother is depressed does not tell you how she is caring for her baby (see articles by Solchany & Barnard and Samartin and colleagues, this issue). Some mothers with depression are able to provide consistently sensitive, responsive care to their children; others are not. We must remember, too, that an individual baby's development is influenced by many factors, including the child's own temperament and the amount and quality of care available from fathers and other caregivers.

One of the main things we worry about when a mother is depressed is whether her baby is getting enough opportunities to experience himself as an effective communicator of both positive and negative feelings. Many depressed mothers respond to their babies' and toddlers' fussing, tugging, or even biting, but not to smiles or positive bids for attention. Babies who have learned from their mothers that only negative strategies get a response are not likely to endear themselves to other adults. Moreover, more passive babies may simply withdraw from social interaction altogether when their depressed mothers don't respond to their bids for attention. When a depressed mother does respond to her baby, she may be irritable, or her face may look sad or "flat." Babies tend to turn away from this kind of facial expression. Mothers may then feel rejected by this behavior and stop holding their babies close and towards them (they may instead turn them facing outward on their laps) – decreasing further the baby's opportunities to experience sensitive and responsive caregiving (Goodman & Gottlieb, 1999).

Again, early identification and treatment of maternal depression are important for both mother and child. The longer a mother is depressed and goes without treatment, the more likely she is to feel less and less competent as a mother and, consequently, worse about herself as a person. Meanwhile, longer exposure to a mother's depression is associated with more problems in young children's development.

Q: How can staff of Early Head Start and other community programs identify and help families affected by maternal depression?

A: We need to recognize, first of all, that depression in mothers of young children is not uncommon; it is a major public health problem. This means that health policy at the national level, community service systems, and programs to

serve expectant parents and families with infants and toddlers should be prepared to identify and help mothers who are experiencing depression. Some experts estimate that as many as 50 percent of the mothers of infants and toddlers who are eligible for Early Head Start have symptoms of major depression. EHS and similar programs must be planned, staffed, and funded to meet the needs of these vulnerable families.

Fortunately, we have an array of evidence-based strategies at our disposal:

- **Outreach to expectant and new mothers, reducing their isolation**, is an extremely important role for front-line staff in community-based programs. In our society, mothers with young children tend to be isolated. Many pregnant women, especially those living in poverty, have little effective or welcome support. Mothers of young children can get caught in a cycle of lethargy, isolation, more depression, feelings of helplessness and hopelessness, and more isolation; their depression itself becomes a barrier to the help they need. A home visitor, reaching out to a pregnant woman or new mother and coming back reliably, week after week, can offer emotional support and assess the safety of mother and child. Outreach workers can also help compensate for the lack of energy and indecisiveness experienced by depressed mothers by bringing them to medical appointments and activities where they can meet other mothers.
- **Support for mothers, children, and husbands and partners** can be accessible and acceptable in Early Head Start and other community programs. Groups for mothers can reduce social isolation and provide social support, as well as offering respite as children are cared for by staff. High-quality infant/toddler child care, with special attention to the needs of children whose development may already be compromised because of the impact of maternal depression, can offer babies relationships in which they experience a full range of affect from their caregivers and their own cues are responded to consistently, contributing to a sense of efficacy in interactions with others. Husbands and partners of mothers who are experiencing depression are worried and often overwhelmed by the demands on them. Programs can offer them peer support, information that demystifies depression, and help with communication and problem solving.
- **Standardized screening tools for depression** are reliable, non-stigmatizing and easy to score. For example, the CES-D (Center for Epidemiological Studies Depression Scale) (Radloff, 1977) is a questionnaire, available in self-report or interview format, with 20 items that asks parents to report how often they experienced both positive and negative feelings during the past week (for example, "I felt hopeful about the future," "I felt I was as just as good as other people," "I

felt that everything I did was an effort," "I thought my life had been a failure."). Staff of community programs can use the CES-D as part of the enrollment process for families, presenting it as a way of learning about how things are going with parents and understanding what their needs might be. Scoring of the CES-D is straightforward; a high score is a reliable indicator of depressive symptoms, correlated with major depression. The National Institute of Mental Health has a self-test for postpartum depression that is available through its Depression Awareness, Recognition and Treatment (DART) initiative (1-800-421-4211 or www.nimh.nih.gov). Once depression is identified, the challenge for program staff becomes establishing a trusting relationship with the mother that will help her get the diagnostic evaluation and therapeutic services likely to be of help.

- **Empirically validated interventions for postpartum depression** would ideally be offered on site at community-based programs, possibly through partnerships with Community Mental Health Centers. Such arrangements would require staff who are trained to work with both very young children and adults. Interventions that have been shown to reduce mothers' depressive symptoms or improve the mother-child relationship include:
 - Individual interpersonal psychotherapy (O'Hara, Stuart, Gorman, & Wenzel, 2000);
 - A mother-infant therapeutic group approach (Clark, Keller, Fedderly, & Paulson, 1993);
 - Home-based interventions for depressed mothers and infants (Gelfand, Teti, Seiner, & Jameson, 1996; Cooper & Murray, 1997); and
 - Relaxation and massage, music, and coaching strategies to improve maternal mood and enhance mother-infant interaction (Field, 1997).

At the University of Wisconsin's Postpartum Depression Treatment Program, we are currently conducting an NIMH-funded clinical trial comparing the efficacy of our mother/infant/family relational approach to the treatment of postpartum depression with individual psychotherapy. This study will examine individual differences in who benefits from what type of intervention, as well as following the psychosocial functioning and development of the children, and the quality of mother, child, and family relationships over two years.

Staff of community-based programs who are working with mothers who are experiencing major depression should also keep in mind the possibility of consultation concerning the use of medication for women who are feeling suicidal, panicky, hopeless or helpless.

Q: Is depression an issue for staff of infant/family programs?

A: Most definitely. As noted earlier, serious depression is not uncommon in the population at large, and even more

prevalent among mothers of young children – including those who work in Early Head Start and other programs serving families with infants and toddlers. In addition, EHS staff, home visitors, and child care professionals are often dealing with economic disadvantage, violent communities, and other adverse circumstances that increase their vulnerability to depression. Finally, we should remember that the emotionally demanding nature of infant/family work – especially with parents and very young children who have mental health problems – stirs up powerful, sometimes uncomfortable or even overwhelming feelings among staff.

Directors of individual programs and designers of multi-site initiatives – like Early Head Start and Healthy Families America, for example – should make sure that all staff members have accurate, user-friendly information about depression and its treatment, as well as health care benefits that include appropriate mental health assessment, diagnosis and treatment. Reflective supervision in infant/family programs is a way to help staff members recognize and deal with the difficult feelings aroused by their work with families. Within the safety of the supervisory relationship, staff members can think about what they themselves need to do to be effective in their professional roles, and how they can proceed to care for their own as well as their families' emotional well being. ♀

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RELATIONSHIPS FOR LEARNING:

Early Head Start Infant Mental Health in Jackson, Michigan

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PHOTO: MARILYN NOLT

It is a gift to have the time and place to reflect on experiences within the rapidly expanding world of infant and family work. I began my journey decades ago as a teacher for one of the first Head Start programs in Michigan, in 1966. Thirty years later, I was asked to be a trainer and consultant to one of the first Early Head Start programs in the country. In the years in between, I had worked as a home visitor, introduced by Selma Fraiberg and Michigan colleagues to the practice of Infant Mental Health. Under their careful direction, I learned about the importance of infancy and early relationship development to one's capacity for learning and relationship experiences throughout the course of life. In the process, I developed a passionate curiosity about early development and relationship work. In my role as an Early Head Start trainer and consultant, I was uniquely challenged to integrate what I understood from my experiences as an Infant Mental Health specialist into the new arena of Early Head Start.

Infant Mental Health: The Michigan Approach

Infant Mental Health services as developed by my Michigan colleagues are intensive and comprehensive.

Parent and infant are seen together, most frequently in their own homes, for early identification of risks and treatment to support the developmental and relationship capacities of both parent and child. Returning to "the source," the home where an infant or toddler and parent live, the Infant Mental Health specialist observes, first hand, the child within the context of the emerging parent-child relationship. Sitting at the kitchen table or on the floor or on the sofa, the specialist attends to the emotional experience and needs of the infant, at the same time curious about the parent's behavior and emotional response. To the extent that

at a glance

- The EHS program in Jackson, MI is a relationship-based model that focuses on the mental health and developmental needs of children and families.
- EHS specialists (home visitors) are master's level social workers or early childhood educators.
- The model is evolving, to support families and children at home and in center-based or family child care.
- Training and regular reflective consultation for EHS specialists are essential for effectiveness.

the specialist understands, supports and sustains parents in understanding and responding sensitively to their infants' or toddlers' emotional needs, an overarching and significant goal of Infant Mental Health services is reached. Treatment strategies vary and may include concrete assistance, emotional support, developmental guidance, early relationship assessment and support, infant-parent psychotherapy, and advocacy. Fundamental to the success of these service strategies is the belief that it is the Infant Mental Health specialist's relationship with the family that becomes the instrument for growth and change (Weatherston, 1995, 1997, 2000; Weatherston & Tableman, 1989).

The Jackson, Michigan Early Head Start Program Model

The Early Head Start (EHS) Program was designed to support the parenting capacities and child development needs of families with infants and toddlers, some of whom could be expected to be highly vulnerable. As EHS was beginning in 1995, the Jackson, Michigan community was fortunate to have an established Infant Mental Health Program, one of more than 35 programs developed to provide home visiting services to children under three years of age and their parents within a statewide system of mental health care. The EHS program model proposed by planners in Jackson was designed to focus on the mental health and developmental needs of children and families enrolled for Early Head Start services. The Infant Mental Health Program provided a cornerstone for the evolution of the new relationship-based EHS model. Within this model, it was assumed that expectant parents and families with very young children would benefit greatly from well-trained practitioners who were prepared at the master's degree level with specialization in social work or early childhood education. The program model called for weekly home visiting by these EHS specialists, as well as socialization groups for interaction and play. The program model later established the option of center-based care for a small number of families with infants and toddlers.

At times, we were uncertain about how to balance developmental goals for young children with the emotional realities of parents or caregivers and the stresses that continuously threaten the stability of their lives. What follows are descriptions of this effort, with an emphasis on the evolution of a model that is dedicated to supporting the developmental capacities of infants and toddlers within the framework of emotional relationships, at home and in center-based or family child care.

Early Training Experiences

As the Region II Community Action Agency Early Head Start started up, we designed a training experience to introduce the new team of EHS specialists to Early Head Start and Infant Mental Health principles and practice. The first task was to provide a context in which the eight

EHS specialists, their supervisor, and I could think about infancy, early parenthood, home visiting work, and ourselves. New to one another and new to the practice of Early Head Start and Infant Mental Health, we very much needed 6 intensive, training days together, a total of 36 hours of training. We met once weekly for 6 weeks. The training modules included:

1. An Introduction to Home Visiting Services: Early Head Start and Infant Mental Health;
2. The Importance of Relationships and Early Relationship Development;
3. Pregnancy and Development in the First Years;
4. Observation and Informal Assessment Strategies;
5. Understanding Risks, Delays and Disabilities in Infancy and Toddlerhood; and
6. Early Head Start Families – Sharing and Responding to Home Visiting Work.

Observing and listening

Throughout each training day, there were opportunities to ask questions about development within the context of relationship, wonder about the meaning of interaction or behavior, consider strategies for effective service, and reflect on personal responses to challenging professional work. For example, while considering the emotional milestones in infancy and early childhood, we watched videotaped interactions of parents and infants at play. "What is at the heart of an infant's emotional well-being?" one specialist asked. "Capacity for relationship," replied another. Others responded: "A baby who can relate well is a baby who will thrive, play joyfully, and be ready to learn when she enters school." "You can see it in their responses to their mothers and one another. They can look and listen, get excited and invite interaction." "They draw one another in. They share their pleasure with one another so easily!"

These observations led to thoughts about other babies and parents whose emotional experiences were quite different. We watched videotaped vignettes of two families: Shana, a silent, solemn, unsmiling six-month old, who asked for very little from her mother, a passive, inattentive, and depressed woman who left Shana alone in the crib for long periods of time with little to look at or play with; and Denise, an irritable three-month-old, easily agitated and difficult to console, whose mother appeared angry and resentful of her demanding baby and overwhelmed by her needs for care. One specialist wondered what each baby was experiencing. "What is it like to be that baby?" Another asked, "What is it like for the mom to take care of her?" I asked them to think about what might be getting in the way of these mothers and babies interacting more positively with each other. Together, we explored what could explain their difficult interactions and behaviors. The specialists had many ideas: "Maybe it's the baby, Shana. She's so quiet. She may be disappointing to her mother." "Maybe her mother lost a baby before her. If she did, it might be hard to care for this one

now." "Maybe she was premature and had to stay in the hospital for some time. There could be a worry about her development." "Maybe the mom is lonely. Maybe no one is around to help her take care of Denise." "Maybe it's the baby, Denise. She's so difficult. She's always fussing."

Learning how to approach and support families

Their careful observations and questions led the EHS specialists to think about ways to support an infant's development through Early Head Start and incorporate Infant Mental Health strategies as they worked. One specialist said, "I would try to sit as quietly as I could in the first visits and learn as much as I could from the mom and baby, although it would be hard. I might ask the mom what she notices that the baby is doing this week. I might ask if she has any questions about her baby's development and offer to bring some developmental materials out." I suggested that it might be important to observe the baby with the parent and ask the parent what the baby is doing. "You might look for an opportunity to offer some developmental information, 'When you talk to the baby, it help the baby learn to talk.' Or, 'When you smile at the baby you are teaching the baby how to smile.' Or, 'When you offer the baby something interesting to play with, you are helping him to practice reaching and grow curious about his world.'" I also suggested that it might also be important to invite the mom to talk about her baby by asking, "Can you tell me something about your baby — maybe what she enjoys or her routine each day? How do you know when she is hungry or tired? What do you like doing with her? What is it like for you to hold her or play with her or feed her?"

I also encouraged the specialists to think about the first weeks at home with a baby. An EHS specialist might ask a parent to talk about the early care of an infant: "What was it like for you when you brought the baby home from the hospital? Who was there to help you take care of her?" The group worked hard to understand how important it is to observe, offer developmental guidance, and ask questions that invite a parent to experience — and share — an emotional response surrounding the development and handling of a baby. The specialists understood that thoughts and feelings are more easily expressed within the context of safe, trusting working relationships. They knew that it would take time for those relationships to develop with Early Head Start families, just as their own relationships within the training group were developing.

Throughout the initial training experience, it was enormously important to consider how to approach families in ways that would lead them to accept the invitation to partic-

ipate with their infants in this new home-based program. The EHS specialists kept two Infant Mental Health assumptions in mind:

- All parents want what is best for their babies, including relationships that are stable and mutually satisfying.
- The birth of a baby into a family offers the hopefulness of a new relationship and the possibility for growth and change.

It was challenging for the EHS specialists to enter families' homes, sit beside parents and very young children, and offer strategies for developmental and relationship support. They went carefully and with optimism, as parents allowed.

For most of the new team, this approach required a dramatic shift in focus — simultaneous attention to an infant, a parent and their developing relationship; awareness of emerging developmental capacities and acknowledgement of strengths; identification of conditions that place an infant or parent at risk for developmental failures; and creation of opportunities for parent-child interaction and exchange. Furthermore, attention to the emotional experience and needs of infants and families enrolled in Early Head Start challenged each EHS specialist to remain open and emotionally available to themselves and to each other. The tasks of EHS specialists include

- the identification of infant and toddler strengths;
- parental guidance to notice developmental capacities and changes;
- parental guidance to interact playfully and appropriately;
- shared acknowledgement of developmental milestones; and
- encouragement for success in school.

While helping parents understand and accomplish these important goals, EHS specialists must also to pay attention and respond to the realities that parents struggle with. From an IMH perspective, this is crucial to successful home visiting and developmental work with children. Balancing what parents were experiencing, thinking about and feeling with the developmental needs of their very young children often presented enormous challenges to the EHS specialists working with young children and families. In addition to poverty, they saw other risks to parents' and children's well being, including depression, chronic mental illness, alcoholism, substance abuse, chronic illness, joblessness, adolescent parenthood, school failure, isolation, homelessness, single parenthood, and domestic and community violence. Of equal importance, parental histories included experiences that heightened the risk — maternal or paternal abandonment, abuse or neglect; parental alcoholism, drug use, and/or chronic mental illness; the death of a parent in childhood;

All parents want what is best for their babies, including relationships that are stable and mutually satisfying.

A GUIDE FOR HOME VISITING WORK WITHIN THE EARLY HEAD START SYSTEM

To promote social and emotional development in infancy:

- **Sharpen the focus of each home visit by observing the infant together with the parent.** Ask the parent what she sees that the infant is doing. Support the parent's developmental awareness of the infant. Wonder with the parent what the infant may do next and think together about how the parent can encourage the infant with that developmental task.
- **Support the parent's understanding of the importance of responsive and playful interactions** to early brain development, emerging developmental capacities, and later success in school.
- **Invite the parent to ask questions** about the infant's development and offer to look for information to answer her questions.
- **Provide developmental information** (handouts, printed material, booklets) to guide parents in interacting pleasurably with the infant and responding to the infant's developmental needs.
- **Maintain your focus on the infant and the relationship** as you inform the parent about early developmental issues, using language such as: "When you talk to the baby it helps the baby learn to talk." "When you smile at the baby it teaches the baby how to smile." "When you respond to the baby's crying you are teaching the baby that he can have an effect on his world." "When you read to the baby you are helping him to listen and pay attention." "When you offer the baby something interesting to play with you are helping him to practice reaching and grow curious about his world."
- **Link/tailor your understanding of early infant development and care to the developmental level and needs of the infant and parent you are visiting** – for example, a 6-month-old baby and an 18-year-old parent with significant cognitive delays or a 10-month-old baby who is failing to thrive and a 34-year-old parent with a diagnosis of depression.
- **Suggest to parents that play activities support early growth and development.** Invite parents to show you what the infant enjoys and responds to. Offer to demonstrate new play activities that are appropriate to the infant's age for example, early baby games, nursery rhymes, songs, and finger plays.
- **Indicate that developmental information may be shared with other family members** — father, grandmother, boy friend, etc.
- **Invite the parent to try a new play interaction with the infant.** Notice the infant's response to the activity. Inquire about the parent's response to the play interaction. Reinforce the pleasure for both parent and child.

- **Guide and support positive interactions** between parent and infant through "floor play" activities during home visit.
- **Support continuing interaction between parent and infant through learning games**, saying, for example, "This is a game your baby will enjoy with you!"
- **Emphasize the importance of the parent's sensitivity and warm response to the infant's cues** as important to the development of their relationship with each other and the infant's attachment security.
- **Help parents to read the infant's cues** (for example, cries and smiles), interpret them, and anticipate what the infant needs, supporting the development of a secure and trusting attachment relationship.
- **Maintain awareness of your own emotional response to the parent and infant** as they interact (or not) and respond to one another (or not).
- **Reflect on what you see and hear with your supervisor/colleagues** during regularly scheduled meetings in effort to support your own growth, professional development and thoughtful work with infants and families.

To promote social and emotional development in toddlerhood:

To promote social development:

- Help parents to **understand and negotiate conflict** with the growing toddler.
- Help parents **help the toddler learn to manage conflicts and disagreements.**
- Help parents to see the important relationship between managing anger or conflict successfully and the **growth of the young child's prosocial behavior and empathy.**
- **Help parents learn to set limits that are firm, reasonable and clear** for the toddler.
- Recognize and **support toddler's emerging capacities to cooperate with others.**
- Help parents to recognize and **reinforce the toddler's capacities to cooperate.**

To promote emotional development:

- Recognize and **support the toddler's developing capacity to have and express a range of emotions** – for example frustration, anger, wariness, fear, anxiety, shame, guilt, pleasure, delight, joy, pride, and love.
- Help parents to **recognize, talk about and reinforce the toddler's capacity to have and express a range of emotions.**
- **Support the toddler's developing awareness of the feelings that other people have and express.**

the death or loss of a child; exposure to domestic violence and community violence; and unresolved relationship loss.

It was not the presence of one factor, but the accumulation of risk factors, past and present, that placed some parents at risk for failure. Overburdened by their own significant social and emotional difficulties, they could not immediately or easily attend to the social and emotional needs of their infants or toddlers. Parental anger, confusion, fear and despair often explained the inability to hold, feed or nurture a young child adequately; offer appropriate playthings; notice, pay attention or read to a child; encourage the child's curiosity or wonder. In these instances, early development and relationship security appeared to be at grave risk.

The Guide for Home Visiting Work within the Early Head Start System (see sidebar, p. 54) suggests some specific strategies to use in home visits to link early development to parent-child interaction and relationship through EHS home visiting services.

Consultation: A Learning Relationship

Reflective consultation helps infant/family service providers to be more effective in their work with families. With this in mind, the supervisor of the Community Action Agency EHS program arranged for mental health consultation to take place regularly throughout each service year. This was consistent with the supervisor's experience and belief that regularly scheduled, individual supervision was fundamental to clinical competency and personal development. (The Head Start Program Performance Standards, revised in 1996, call for a regular schedule of on-site mental health consultation).

Careful observation of the infant and parent(s) together, gentle questioning and thoughtful listening are requirements for successful intervention. The same might be said for successful consultation. The EHS specialists organize an abundance of information about infants and toddlers, families, early developing relationships and the caregiving environment. As they bring the details of home visits to consultation, it becomes possible to consider infant competencies, disturbances and risks. They also think about the parent(s), their capacities to nurture and respond to the infant, their worries and their hopes. As they begin to feel trusting of the consultant and the process, they look more closely at the feelings awakened in the presence of particular parents and infants. At its best, the consultation, like supervision, is a learning relationship, (Bertacchi & Coplon, 1992) offering a place for questioning, shared understanding, guidance and support.

Emotionally present, the consultant follows the EHS spe-

cialist's lead, attending to verbal and non-verbal cues, observing carefully and offering guidance or an empathic response. Devoted and invested, the consultant serves as a continuing source of knowledge and support. She/he offers reassurance and praise as appropriate, building each specialist's confidence in observing, assessing, understanding and supporting infants and families referred to EHS.

As relationship-based services to infants and families have increased, practitioners and supervisors have written about the importance of the supervisory relationship to effective service designs. Rebecca Shamoon-Shanok (1992) writes, "When it is going well, supervision is a holding environment, a place to feel secure enough to expose insecurities, mistakes, questions and differences" (p. 37). The same might be said about consultation. It is a holding environment. Safely held, the EHS specialists grow more resourceful and confident, informed about the observations they make and increasingly emotionally available to the families they serve. At the same time, they may begin to consider personal responses to the professional relationships they have

entered (Bertacchi & Coplon, 1992; Schafer, 1992). The depth and intensity of the consultation relationship vary according to individual experiences and needs. Important to Selma Fraiberg's original training model, the consultation relationship continues today to be most significant to the learning process (Fenichel & Eggbeer, 1990; Schafer, 1996).

Keeping our balance

As our work together continued, the EHS specialists, the supervisor and I realized that we were at risk in consultation for failing to pay atten-

tion to worrisome aspects of the infant or toddler's development as we paid increasing attention to the parent's social and emotional needs. It was an astonishing parallel to the EHS specialists' experience! As was the case for some EHS families, we were also at risk for overlooking the emerging capacities and strengths of the infant as we paid increasing attention to the developmental risks and failures facing parents. Together, we struggled to find our way back to "the child," balancing present observations of the infant or toddler, the parent, and their capacities with knowledge of past realities and present risks. "What about the baby?" we asked. "What capacities does the baby bring to elicit interest and care?" "Is the baby able to woo her mother with a gurgle or smile? Or is she avoidant of her mother's face and voice, turning quickly so not to catch her stare?" "How does the baby communicate wants and needs or respond to cues?" "How curious is the toddler? What is his response to his mother's leaving him in child care? How emotionally available is he to you?"

Careful observation of the infant and parent(s) together, gentle questioning, and thoughtful listening are requirements for successful intervention.

A format for case discussion

We developed a format for case discussions and presentations that helped us to keep our eyes on early development and relationship as we considered strategies to support both parent and child. Key points included:

- the reason for referral to EHS, the parent's understanding of why the EHS specialist is visiting;
- a description of the infant or toddler (individual characteristics, temperament, size, weight, developmental capabilities and emerging strengths);
- a description of one exchange (at play, feeding, diapering, holding, etc.) between parent and child that was meaningful, illustrating the baby's interest in the parent and the parent's capacity to respond to the child;
- the use of a 3-minute video clip of the parent and child together, if available, to observe and discuss;
- a summary of the parent's observations of the baby, what she/he sees and cherishes as well as expressed concerns;
- strategies that the EHS specialist has tried to support emerging competencies;
- consideration of infant and parent needs;
- any knowledge of early infant experiences or parental realities and history that might explain the worry about the baby, the developing relationship, or the parent's capacity to provide appropriate care.

It was also crucial to allow room during consultations for expression of thoughts and feelings awakened in the EHS specialists as they carried out their home visiting work. The format provided a structure that encouraged us to keep our eyes on the baby as the team learned to listen to the parent and at the same time to contain the intense emotions encountered in EHS work. After four years of work, we still use this format and carry a continuous awareness of the ease with which we can be pulled into the parent's realities, past and present, and lose sight of the child.

Handling emotional upheavals: Personal and professional

Several strategies that come from an Infant Mental Health approach are particularly useful in understanding and expressing emotion. For example, listening, offering a context in which very young children and parents can express themselves through their interactions and at play, accepting what the family offers to us, and "allowing feelings to be there" invite the EHS specialist to experience, understand and support development within the context of the parent-child relationship. Caught up in the emotional struggles of very difficult infant and family work, EHS specialists often feel angry, despairing, discouraged, disorganized and afraid.

Together, we have learned to allow these feelings to be there during consultation, to share them with each other, to talk about them, and to use them to better understand the parents, their struggles with their infants, and ourselves. As we have grown in our ability to do this, we are better able to attend to the child development goals of Early Head Start, incorporating the strategies that are more traditionally identified with Infant Mental Health.

Early Head Start and Infant Mental Health programs offer experiences that encourage optimal development within the context of healthy parent-child relationships. Each infant or toddler and each parent, mother and father, deserves our offer of guidance and support to reach that goal. This belief is fundamental to the work that all of us do.

Janna, Charisse, and Jared: A Year in Early Head Start

What follows is a story told through initial observations by the EHS specialist, a description of a consultation in which the EHS specialist presented her observations, and an account presented in a follow-up consultation, approximately one year later.

When she began her work with the family, the EHS specialist had recently earned her master's degree in early childhood and her social work licensure. She was new to the practice of infant mental health but had had years of developmental experience within Head Start. The summary illustrates the complexity of the work and the challenges that EHS specialists face.

The EHS specialist's observations

Come with me into the living room. It is approximately 2 o'clock in the afternoon. Dishes clutter the

tabletop and the ashtray is full. The room is hot. The windows are shut and the shades are drawn as if to protect against the intrusion of daylight. The 15 month old protests. She wants to get out of the playpen she is confined to. Her mother ignores the shrieks. She finally sets the toddler free and the child begins to crawl about. She doesn't walk yet. The baby, 3 months old, restrained in his infant seat, fusses in the next room. The toddler is curious about me and comes over to take a closer look. Her face is smudged with traces of lunch. She uses no words, just tugs at my sleeve to invite my interest. I am tempted to pick her up, but refrain from doing that, knowing that her mother, distracted and anxious, also needs my attention.

A nurse made the referral several weeks ago. She was concerned about the baby's slow weight gain, the toddler's development and the mother's apparent lack of pleasure in either child. When I called to ask about the mother's interest in EHS, she agreed to let me come, but she sounded less than

**It takes a great deal of
courage to observe a baby
or toddler closely and feel
their distress.**

enthusiastic. "I'll be here, but I don't know what you can do."

As I sit at the table, I see that she is easily overwhelmed by the care of two small children. She does not seem to recognize the toddler's needs for attention or stimulation. She grows impatient with her daughter as she continues to pull up to the table and reach for the ashtray. "No!" she says harshly. She reaches to take the cigarette butts from the toddler's hand, but the toddler crawls quickly away, ignoring her mother and now out of reach. The mother shouts, "Come here!" New at this job, I watch and listen ever so carefully, trying to make sense of what they are showing me, but uncertain about what to say. I wonder how often one of them has reached out only to have the other turn or move away. I wonder what explains the struggle between them. I comment quietly, "She crawls pretty quickly! How do you keep up with her and the baby, too?" The mother smiles, "She is quick. Gets away from me now." I continue to describe what I see—a young toddler who is fairly coordinated, although delayed in walking. She is curious and quick. I ask the mother what her child's name is. "Charisse," she says. I then ask if there is something she likes to do with Charisse. "Well, we used to have fun together, just her and me, until the baby came and was so sick and everything." I invite the mother to tell me more about this. As if no one has asked or listened to this story before, she begins to tell me:

The baby came too early. They had to take him from me. He wasn't breathing. He was very small, too. They held him up for me to see, but then they took him away in a hurry. I couldn't hold him for almost a day. It was really scary and for a while I didn't think that he was going to live.

The story is a difficult and painful one, but I try to remain attentive and respond by saying, "How very frightened you must have been! That was a very difficult beginning for you and for your baby."

The mother tells me a little more and I notice some relief. She glances again at Charisse, who has moved closer to her feet. She reaches out to her and this time she allows her to pull herself on to her lap. I notice that it is almost time for me to leave and say, "Our time is almost up. What has happened is very difficult and important for you to talk about. I could come back next week if you would like." The young mother agrees and before she lets me out, she sets Charisse down on the chair and goes to get the baby. "He was crying real hard. Maybe he's hungry. Hold him while I get the bottle filled," she demands and thrusts the baby into my arms.

I notice that the baby has no hair and avoids looking at me. His arms thrash about, making it difficult for me to hold him easily. He continues to cry and I call out to his mother, "He's pretty upset. He seems to be looking for you!" The mother returns with a warm bottle of milk, takes the baby and begins to feed him. They both settle down. I say quietly,

"That's just what he wanted, you and his bottle!" I am distracted by Charisse, who now lies quietly on the floor, slightly withdrawn, rocking side to side, and sucking her pacifier. I would like to stay, but need to go. "Bye-bye, see you next week," I tell her. "I'll come next Tuesday at 1 o'clock in the afternoon."

I leave, feeling overwhelmed, emotionally exhausted and ambivalent about going back. I'm really hungry and drive away as quickly as I can to the nearest McDonald's I can find. Once fed, I settle down and wonder about the hour's home visit. "What about the baby?" I hardly got a glimpse. He looked so tiny and distressed. "What about the toddler?" She was fussy, lively, then so quiet. I wonder if she has some significant delays. "What about their mother? Does she have family or friends around to help her? Is she caring for these children by herself? What made her so unable to understand and respond more immediately to what her children needed? Where is the baby's father?" Many questions dance around in my head.

I was also aware that I felt somewhat overwhelmed. Where would I even begin? Will I be able to support the mother's interest in her babies? Will I be able to guide her through floor play activities with either child? How overburdened is she? More importantly, will I be able to keep my eyes on everything here?

A scene from a consultation meeting

The EHS specialist brings the details of this initial visit to her supervisor and also to the next consultation group. She tells the group, "Jared (the baby boy) looked so lonely. He was strapped into his infant seat almost the whole time I was there. Janna (the mother) didn't pick him up, until the very end. She didn't seem to notice her baby's discomfort or her other child, either, for that matter!"

The consultant and EHS team listen to the poignant description and acknowledge that it takes a great deal of courage to observe a baby and toddler closely and feel their distress. The specialist describes the mother as "young, alone and frightened. She could hardly look at me when she talked!" The consultant again acknowledges how strong one has to be to experience the neediness of a mother who appears lonely and afraid. The specialist wonders how she will be able to help them. "They need so much and I am so new at this work." Her own uncertainty is clear. The consultant offers supportive comments: "You learned so much in this first visit that will be helpful in understanding what the baby and his sister and mother might need. You are such a good, careful observer and listener."

The consultant continues by inquiring about what the EHS specialist thinks the baby needs right now. "I guess he needs someone to notice that he is there, to hold or comfort him when he cries, and to offer something to eat when he is hungry." The consultant agrees and wonders about the toddler. "Well, she is pretty spunky, really. I think she could begin to walk if her mother encouraged her. She was bright-

eyed and eager at first, but then shut down when she didn't get the attention she really wanted. I think she wanted to be picked up and held, too."

The consultant asks the group how these observations might guide the specialist in planning for the next visit. "You could notice what each is doing. You know, really pay attention to the baby and the toddler and the mother, too." "They need more opportunities to look and play with things. You could bring a few toys for the mother to enjoy with each child." The consultant notes that the specialist's observation about "holding" was a very thoughtful one. "You may want to pick the baby up out of that seat and hold him or hold the toddler, too! I wonder what would happen if you didn't do those things, but responded to their need for 'holding' by holding them with your presence and also with your words. It was so important that you went. You were very attentive and emotionally present. You might invite the mother to tell you more about the baby; she seemed to respond to that. You might be the first person to have asked this. You have a very empathic style. She seems pretty overwhelmed! Your being there is really important. If her eyes wander to the toddler, ask her to talk a little more about her, what kind of a child she is, what she likes to do now or even what they once enjoyed together. Reassure her that you will come back, too."

The specialist looks more confident; the color returns to her face. Before the hour ends, the consultant wonders what it was like for the group to process the visit together. One member of the team recognizes how angry she found herself feeling, angry with a mother who overlooks her children's needs. Another realizes how hopeless she felt about the neediness of this whole family and the lack of resources to adequately meet everyone's needs. A third felt frustrated and impatient with a mother who had had two babies so close together. The group recognizes that those feelings – angry, hopeless, frustrated, and impatient – might reflect the feelings that the infant, toddler and parent shared, too. The EHS specialist might keep those in mind as she continues her work with the family and could identify those feelings at appropriate times. When the session ends, the consultant reminds the specialist, "They are so lucky to have you take an interest in the baby's development and in the toddler's care. I imagine no one else has watched or listened so intently. I'll be thinking of you."

Follow-up consultation

A year later, the EHS specialist again presents her work with the family to the consultation group. Her summary teaches us so much. During her work with the family she learned that this mother had lost an older child: "Paralyzed, she at first could not respond. She allowed her parents to care often for Charisse. She just couldn't do it. She was filled with guilt and remorse. At the time I met them, she had just brought Charisse back. She had another baby to care for then, too." The specialist went on to explain, "I helped Janna see the uniqueness of each of her children. I invited her to

describe each one, her older one too. We discussed their unique personalities as precious gifts to the family. I provided empathic listening and support to Janna, allowing her to express her grief. By acknowledging the validity of her feelings and allowing her to talk about them, she was able to pay greater attention to her children and move on."

Later, the specialist describes Jared and the relationship between him and his mother. "She clearly loves and adores her son and has described him as 'mommy's boy.' Everyday interactions are playful and offer lots of opportunities for pleasure and pride in what he can do. They played a fun game of 'peek-a-boo.' Jared engaged his mom in the game by pulling her blanket over her face and awaiting the familiar question: 'Where's Jared?' Jared pulled the blanket off and revealed his mom's face. Mom replies, 'There he is!' Both laugh joyfully together. Jared repeats the sequence. I watch with pleasure, then take the opportunity to comment on Jared's emerging cognitive and social skills at 15 months. 'He has such fun with you! He's learning that he can have some control over the game and can make it continue. He is also practicing being away from you and learning that you always come back into view!' This is useful because Janna has returned to work. She and Jared both have to learn the same lesson — that each will always 'come back.'"

Grief could have taken a terrible toll. Infant Mental Health work in the context of Early Head Start reduced the risks for this family, as the EHS specialist learned to look at and listen to the infant, the toddler, and the parent, balancing past with present, and offering her relationship as the primary tool for learning. ♦

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INFANT MENTAL HEALTH AT HOPE STREET *Is Everybody's Business*

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The Hope Street Family Center
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At the Hope Street Family Center's Early Head Start program, infant mental health is everybody's business. Our ecological approach to promoting the wellness of the entire family begins with an effort to understand the infant within the context of his or her family, community, and culture. Interventions focus on the relationship between the baby and the primary caregiver, are sensitive to culture, and are tailored to address specific family and individual needs.

An infant mental health perspective is woven into all components of our Early Head Start Program. While we employ two full-time psychotherapists with advanced degrees, all members of our multidisciplinary staff team share the responsibility for maintaining a therapeutic and encouraging environment for participating families, and for planning and implementing mental health interven-

tions. The therapeutic relationship that is established between the home visitor and an infant or toddler's primary caregiver is the foundation for effective mental health and case management interventions. The child development specialist, who conducts assessments in concert with the home visitor and parent, plays a critical role in identifying mental health and developmental problems related to the infant, and in planning interventions that address both developmental and mental health concerns. We see parents as key participants in the mental health planning team, rather than as passive recipients of mental health services. When it is working at its best, the collaborative partnership established with parents at the time of intake allows this vision to become a reality.

When staff refer families to mental health agencies outside the Hope Street Center, we maintain a team-based approach by encouraging outside clinicians to become part

of an integrated plan for mental health intervention on behalf of a child and family, rather than seeing themselves as the sole providers of mental health services. This approach is especially important given the fact that 95 percent of our clients are new immigrants from Mexico and Central America. While attachment disorders and other parent-child problems are the most common mental health issues we see, many participating families experience the stress of acculturation, loss and grief, emotional trauma related to the atrocities of war in their countries of origin, childhood abuse, severe financial hardship, and chronic exposure to violent crime in their neighborhoods. Although Hope Street Family Center maintains formal agreements of collaboration and mutual support with various community agencies, very few of these agencies provide services for uninsured clients (the majority of our adult clients are uninsured). Fewer still employ bilingual licensed mental health professionals who have training or experience working with infants and toddlers, or who understand the cultural issues specific to Hope Street families.

To meet the challenges involved in establishing and maintaining a multidisciplinary mental health approach, we provide mental health-related training and support for all staff. Weekly case conference meetings and reflective supervision help staff maintain a focus on infants' and families' mental health issues, and clarify roles, responsibilities, and objectives. We take special care to hire staff who have the fortitude and sensitivity to work effectively with families under a variety of potentially stressful circumstances. We then try to support staff through collaborative, solution-focused weekly supervision, gently encouraging them to explore feelings and attitudes related to their work with families, and to use the support available to them within the team or in the larger organization.

The story of the Martinez family¹ illustrates the Hope Street approach to infant mental health.

The Martinez Family

When the Martinez family enrolled in the Hope Street Family Center they had two sons, Carlos and Jose, ages 2 and 4, who had both been diagnosed with severe language delays. Their youngest child, Melanie, a healthy and active one year old, was beginning to display subtle predictors of an encroaching language delay as well.

Both parents were anxious to take steps to prevent this. Before enrolling in the Early Head Start (EHS) program at Hope Street, Mr. and Mrs. Martinez had been diligent in their follow up with the local Regional Center for early intervention services. Without outside advocacy or support, they saw to it that their sons received the appropriate interventions, including speech therapy, special education, medical assessments and ongoing evaluations to determine

the origin of their delays and identify treatments that would help overcome them. However, neither Regional Center nor medical assessments yielded information about the genesis of the boys' language disorder because organic factors could not be identified. Examiners concluded that the delay might have an environmental cause.

Hope Street staff found it difficult to believe that factors in the caregiving environment had a negative role to play in the children's development. The Martinez family appeared to be high-functioning in every regard. Mr. Martinez was employed as a factory foreman. Although his income was modest, he was able to provide for his family without public assistance. Mrs. Martinez was a homemaker and looked after the children, seeing to it that they attended doctor's appointments and therapy appointments without fail while keeping the family's roomy subsidized apartment tidy and clean. The family had a network of support in the community. They were active in the Church and had many friends and family members close by with whom they spent time on weekends. The children were friendly and enjoyed the ECE (Early Childhood Educational) visits with their home visitor. Both parents were eager to learn more about how to stimulate their children's development. Mr. Martinez presented himself as an intelligent, committed father who possessed obvious leadership qualities. While shy, Mrs. Martinez was easily engaged and extremely cooperative with the requirements of the EHS program.

The initial contact had been made by the Outreach Coordinator, who shared her initial impressions of the Martinez family with the rest of the team. Care was taken to assign a Home Visitor whose personal and professional characteristics would provide the best fit with the family's strengths and needs. The Home Visitor used her interpersonal skills and sensitivity to engage with the family and to establish the trusting base upon which further work could take place. As she helped the family understand the types of support the EHS program offered she also encouraged them to explore their needs and goals as a family and as individuals. It was only after the initial assessment had been completed that the Home Visitor began to suspect

at a glance

- An ecological approach to infant mental health requires understanding the infant within the context of family, community, and culture.
- At Hope Street Family Center's Early Head Start Program, all members of its multidisciplinary team share responsibility for planning and implementing mental health interventions.
- Staff are supported through training, case conferences, and weekly reflective supervision.
- Offering families choices that allow them to exercise their unique strengths engenders hope and motivation for change.

¹ Names and other details have been changed to protect confidentiality.

that Mrs. Martinez's shyness might not be a natural aspect of her personality, but rather a symptom of longstanding depression. She decided to consult with the Mental Health Coordinator, who, after meeting with Mrs. Martinez, confirmed the Home Visitor's concerns. Mrs. Martinez told the Mental Health Coordinator and the Home Visitor that during most of the eight years of her marriage she had suspected that her husband was being looks unfaithful. She had never been able to address these concerns with her husband because whenever she attempted to do so, the resulting tension in the home was intolerable. Over the years her suspicions grew and eroded her sense of control and self-esteem. It had taken considerable courage for Mrs. Martinez to articulate her fears with her Home Visitor and the Mental Health Coordinator. She said that the trust she felt and the opportunity she was given to explore her feelings in a safe and nurturing environment had given her the courage necessary to confront her fears. The relief she felt after having done so was obvious.

As she continued to visit the family, the Home Visitor observed that Mrs. Martinez's depressed demeanor remained when she interacted with her children. She talked very little with them. The children mirrored her blunted facial expressions and slumped posturing during ECE activities. It was possible, indeed probable, that while Mrs. Martinez had attended to her children's basic needs, she had been emotionally unavailable to them for several years while her psychological energy was consumed with concerns about her marriage and managing the resulting depression.

As with all new cases, the Home Visitor prepared and presented a comprehensive family assessment to a multidisciplinary team of professionals, including peers and members of the other program components: Child

Development, Mental Health, Social Services, Health and Even Start Coordinators. Support and feedback were provided to the Home Visitor, who then incorporated these various perspectives into the service plan she developed with the family. The team agreed that a tension-filled environment and lifelong exposure to a depressed and emotionally unavailable parent could be significant factors contributing to the children's language delays. Regional

Center services, strictly focused on language concerns, did not address these subtle, yet devastating family issues. The Hope Street team made preliminary plans to address the psychosocial concerns in the family through a multimodal approach that empowered the parents as partners in the planning and service delivery.

With this plan in mind, the Home Visitor continued to provide clinical support by working with the children, listening to Mrs. Martinez's concerns and gently reminding her of the options available within the program to address them and encourage Mrs. Martinez to consider her options. During her weekly supervision meetings, the Home Visitor discussed her ongoing observations of and interactions with all members of the family, and was careful to monitor her own emotional responses to the difficult issues being raised. Soon after, family tension escalated when Mr. Martinez disclosed to his wife that he had in fact been unfaithful for a number of years. The team used

this family crisis as an opportunity to plan with the family. Both mother and father immediately agreed to be involved in intensive marital therapy, as they wanted to do anything they could to keep their family intact. In addition, Mr. Martinez agreed to attend a self-help group that addressed the problem of sexual addiction, and Mrs. Martinez entered individual therapy to address her low self-esteem and depression.



PHOTO: MARILYN NOLT

These steps were only the beginning of the family's commitment to a plan for change. Mrs. Martinez acknowledged that she needed help with her children and enrolled in the Even Start Literacy program, which required her to attend ESL (English as a Second Language) classes daily while her children received the benefit of an enriched classroom environment. In this program, she was able to enhance her own self-esteem by creating a network of peers and actively working on her educational goals. Moreover, she engaged in activities with her children that encouraged her to be emotionally present with them as she learned how to enhance their development and prevent further speech and language delays.

In addition to his diligent commitment to therapy, Mr. Martinez became actively involved in the EHS program. He decided to apply his leadership skills to the program and has regularly attended all Parent Committee meetings, where he is a strong presence. Mr. Martinez's participation in the Parent Committee is helping him to work through his own need to re-engage with his family and to grow personally as a leader and community member. All three children regularly attend classes that address their age-appropriate developmental needs. While Carlos and Jose's language development is still delayed, they are making progress; Melanie has remained age-appropriate in all developmental domains, including speech and language.

Addressing the ongoing comprehensive needs of the Martinez family requires an integrated team approach to service delivery. The Home Visitor, in managing the family support and early educational needs of this family, regularly consults with the Child Development, Mental Health, Social Services, Health and Even Start Coordinators. Case conferences involving all of these individuals allow various perspectives to be considered in the assessment of the family's issues, with particular emphasis on environmental factors that could be affecting the boys' language delays. The resulting service plan takes full advantage of the multiple opportunities present within the EHS program. The Home Visitor's case management skills help the parents work smoothly with the Regional Center and School District. Center-based intervention promotes Mrs. Martinez's emotional progress and personal goal setting. Center-based intervention also allows the children an opportunity to socialize with peers in a positive and structured environment and offers their mother a chance to witness many examples of positive, emotionally responsive parenting. The Child Development Specialist uses her expertise to refine the educational approach during home visits and in the center-based activities. Finally, both parents are involved in traditional psychotherapy that addresses their marital issues and their individual concerns. All traditional and non-traditional interventions address the relational, individual and environmental concerns that the team identified as mental health factors that significantly contribute to the children's language delay. All

members of the team see themselves as playing a role, not only in mental health intervention for this family, but in the developmental, educational, and family development realms as well.

The Martinez family continues to participate actively in the Hope Street Family Center. While developmental and broader family issues are not yet resolved completely, both parents are committed to the process of healing and say that their family has never felt more stable and hopeful about the future. We have come to realize in our work with the Martinez family, and other families as well, that an essential aspect to engendering hope and motivation for change comes from offering families choices that allow them to exercise their unique strengths when planning how they will reach their goals. ♦



PHOTO: MARILYN NOLT

EN HOPE STREET LA SALUD MENTAL DE NIÑOS

Es La Responsabilidad de Todos

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En el programa Early Head Start del Centro Familiar de Hope Street la salud mental de niños es la responsabilidad de todos los que trabajamos en el Centro. Nuestro método para promover el bienestar de toda la familia comienza con nuestro esfuerzo de comprender al bebé como miembro de su familia, la comunidad en que vive, y la cultura a que pertenece. El punto mas importante de nuestras intervenciones es la relación entre el bebé y el terapeuta principal, tomando en consideración la cultura, y las necesidades familiares e individuales.

La perspectiva de la salud mental del niño esta presente en todas las partes que componen el programa Early Head Start. Además de los dos terapeutas con altas calificaciones

clínicas que mantienen horarios regulares, todos los otros miembros de nuestro grupo multi-disciplinario también comparten la responsabilidad de mantener un alto nivel te-rapéutico y estimulante para las familias participantes, además del planeamiento e implementación de los tratamientos de salud mental. La relación terapéutica que se establece entre el Visitador Social y el terapeuta principal es la base para una efectiva implementación de estos tratamientos y la administración de cada caso. El especialista en desarrollo infantil, que conduce evaluaciones conjuntamente con el Visitador Social y los padres, desempeña un papel muy importante identificando problemas mentales y de desarrollo en el niño, y planeando tratamientos para resolver esos problemas. Nosotros consideramos a los padres como miembros

principales del grupo de salud mental, no como recipientes pasivos de estos servicios. Cuando el Programa funciona en su mejor forma, la colaboración y estrecha relación establecida con los padres al momento en que ellos ingresan en el Programa hace que esta visión se convierta en realidad.

Cuando nuestro personal refiere familias a agencias de salud mental fuera del Centro de Hope Street, nosotros mantenemos el concepto de grupo invitando a los clínicos de esas agencias a formar parte de un plan integrado de salud mental para beneficio del niño y su familia, y no considerar a la otra agencia como la única proveedora de los servicios.

Este método es especialmente importante, dado el hecho de que el 95% de nuestros clientes son inmigrantes recientes provenientes de México o América Central. Aunque trastornos en la relación de afecto y otros problemas entre niños y padres son las cuestiones más comunes de salud mental que nosotros encontramos, muchas familias participantes experimentan tensión causada por la diferencia entre las dos culturas, sentimiento de pérdida y tristeza, trauma emocional causado por las atrocidades de la guerra en sus países de origen, abuso infantil, problemas financieros graves, y la frecuencia de crímenes violentos en el vecindario donde viven. A pesar de que el Centro Familiar de Hope Street mantiene contratos formales de colaboración y apoyo mutuo con varias agencias de la comunidad, muy pocas de estas agencias ofrecen servicios a clientes que carecen de seguridad (la mayoría de nuestros clientes adultos carecen de seguridad). Muy pocas agencias emplean profesionales licenciados bilingües con entrenamiento o experiencia para trabajar con niños y bebés, o que comprendan las cuestiones culturales inherentes a las familias de Hope Street.

Con el objeto de establecer y mantener un método multi-disciplinario en los servicios mentales, nosotros proveemos entrenamiento en tópicos relacionados con la salud mental además de brindar apoyo a todo el personal. Las sesiones semanales donde se discuten los distintos casos y se identifican y critican varias alternativas ayudan al personal a concentrar su atención en los problemas de salud mental de niños y sus familias, y a clarificar las funciones de cada cual, sus responsabilidades y objetivos. Nuestra agencia toma un interés especial en emplear personas que tienen la fortaleza y sensibilidad para poder trabajar con efectividad con familias bajo circunstancias que tienen el potencial para ser altamente tensas. En esos casos, nosotros tratamos de apoyar al personal con sesiones semanales de supervisión colaborativa con énfasis en la solución de problemas. En estas sesiones el personal es alentado a explorar sentimientos y actitudes relacionados con su trabajo con las familias, y a utilizar el apoyo que se les ofrece en el grupo o en otras partes de la organización.

¹Nombres y otros detalles han sido cambiados para mantener la confidencialidad.

La historia de la familia Martínez¹ es un ejemplo del método utilizado por Hope Street en el tratamiento de la salud mental de niños.

Familia Martínez

Cuando la familia Martínez se registró en el Centro Familiar Hope Street tenían dos hijos, José y Carlos, de 2 y 4 años. Ambos habían sido diagnosticados con severo retraso en la facultad de hablar. La hija más pequeña, Melanie, una niña saludable y activa de un año de edad, también estaba dando muestras de principios de retraso en el hablar.

Ambos padres estaban ansiosos de hacer algo para evitar esta situación. Antes de registrarse en el Programa Early Head Start, el señor y la señora Martínez habían sido muy activos en sus relaciones con el Centro Regional local. Aún careciendo de alguien que abogara por ellos y los apoyara, ellos procuraron para sus hijos tratamiento de terapia de dicción, educación especializada, asesoría médica y evaluaciones periódicas para determinar el origen del problema médico y los tratamientos para curarlo. Los servicios del Centro Regional y las evaluaciones médicas no ofrecieron mucha información acerca del origen del atraso en el hablar observado en ambos niños. No se pudo determinar que fuera causado por factores orgánicos, por lo que se concluyó que podría ser originado por el medio ambiente.

Sin embargo, era difícil creer que el medio ambiente fuera un factor negativo en el desarrollo de los niños. La familia Martínez parecía ser competente en todos los aspectos. El señor Martínez estaba empleado como supervisor en una factoría y ganaba un salario modesto, pero era capaz de mantener a su familia sin necesidad de ayuda pública. La señora Martínez era ama de casa y cuidaba a sus hijos, ocupándose de que asistieran puntualmente a las citas médicas y de tratamiento. Además, ella mantenía el espacioso apartamento donde vivían limpio y recogido. La familia Martínez tenía un grupo de apoyo en la comunidad.

sumario

- Un enfoque ecológico a la salud mental de los bebés requiere entender al bebé dentro del marco de su familia, la comunidad en que vive, y la cultura a que pertenece.
- En el Programa de Early Head Start del Hope Street Family Center, todos los miembros del grupo multidisciplinario comparten la responsabilidad del planeamiento e implementación de las intervenciones relacionadas con la salud mental.
- La efectividad de los miembros del personal se obtiene por medio de entrenamiento, conferencias y discusiones semanales de las distintas alternativas disponibles en cada caso.
- Por medio de las distintas opciones ofrecidas a las familias, se les permite que utilicen sus propios esfuerzos lo cual promueve la esperanza y la motivación para efectuar los cambios que sean necesarios.

Participaban en actividades religiosas y tenían muchos amigos y familiares con los que pasaban los fines de semana. Los niños eran amigables y disfrutaban de las visitas de la Visitadora Social del ECE. Ambos padres estaban ansiosos de aprender más acerca de la forma de estimular el desarrollo de sus hijos. Más aún, el señor Martínez parecía ser un padre inteligente y motivado que obviamente poseía cualidades de liderazgo. Aunque tímida, la señora Martínez se interesaba con facilidad y cooperaba mucho en cumplir con los requerimientos del Programa.

El contacto original fue hecho por la Coordinadora Social, la cual compartió sus observaciones de la familia Martínez con el resto del grupo. Se tuvo cuidado en seleccionar una Visitadora Social cuyas características personales y profesionales se ajustaran mejor a las necesidades de la familia.

Fue después que la evaluación inicial se había completado que la Visitadora Social empezó a sospechar que la timidez de la señora Martínez no era un atributo normal de su personalidad, sino probablemente que un síntoma de una larga depresión. La Visitadora decidió consultar con la Coordinadora de Salud Mental quien, después de entrevistarse con la señora Martínez, confirmó la preocupación de la Visitadora Social. La señora Martínez dijo que durante la mayor parte de los ocho años de su matrimonio ella sospechaba que su esposo le era infiel. Ella nunca fue capaz de discutir esto con su esposo, y cada vez que trataba el resultado era una tensión intolerable en su hogar. A través de los años esta sospecha fue creciendo y afectando su sentido de control y estimación propia. La señora Martínez tuvo que hacer acopio de todo su valor para poder articular sus temores a la Visitadora Social y a la Coordinadora de Salud Mental, pero la tranquilidad que tuvo después de haber hecho esto fue muy visible.

La Visitadora Social notó en visitas posteriores que la

actitud depresiva de la señora Martínez se reflejaba en su relación con sus hijos, y que su comunicación verbal con ellos era mínima. Sus hijos imitaban su expresión facial y asumían una postura indolente durante las actividades en el ECE. Era posible y probable que aunque la señora Martínez atendía a las necesidades básicas de sus hijos, por varios años ella no había estado emocionalmente cerca de

ellos debido a que toda su energía había sido consumida por la preocupación con su matrimonio y tratando de controlar la depresión originada por esta situación.

Como en todos los casos nuevos, la Visitadora Social preparó y presentó una evaluación completa de la familia al grupo multi-disciplinario de profesionales, incluyendo miembros de su misma profesión y de otros departamentos del Programa. Este grupo ofreció apoyo y comentarios críticos a la Visitadora Social, la cual incorporó estos últimos al plan de servicios que ella había preparado con la familia. El grupo estuvo de acuerdo que un ambiente hogareño lleno de tensión y una vida entera expuesta a una madre deprimida y emocionalmente ausente pudiera ser un factor importante y contribuyente al retraso en la facultad de hablar de los hijos. Los servicios del Centro Regional que estaban exclusivamente enfocados al problema del lenguaje, no tomaban en consideración estos sutiles pero devastadores problemas familiares. Se

prepararon planes preliminares para tratar los problemas psicológicos de la familia utilizando métodos múltiples que le permitían a los padres como miembros del grupo participar en el planeamiento y en la forma de ofrecer los servicios necesarios.

Con este plan en mente, la Visitadora Social continuó ofreciendo ayuda clínica y alentando a la madre a considerar las distintas opciones que ella tenía. Los problemas clínicos que surgieron, y el impacto emocional en la



PHOTO: MARILYN NOLT

Visitadora Social, fueron discutidos durante las sesiones semanales de supervisión de la Visitadora Social.

Poco después la tensión familiar aumentó cuando el señor Martínez le confesó a su esposa que era cierto que por varios años él había sido infiel. El grupo vi esta crisis familiar como una oportunidad para envolver a la familia en el planeamiento de los servicios. Inmediatamente, ambos padres aceptaron un tratamiento de terapia marital intensiva, ya que ellos querían hacer todo lo necesario para mantener su núcleo familiar intacto. Además, el padre aceptó asistir a un grupo de ayuda que ofrecía tratamiento para la adicción sexual. La madre también recibió sesiones individuales de terapia para contrarrestar su depresión y la falta de estimación propia.

Sin embargo, eso fue sólo el comienzo del compromiso de la familia para efectuar los cambios necesarios. La madre aceptó que ella necesitaba ayuda para poder atender a todas las necesidades de sus hijos y se registró en el programa Even Start Literacy, que requería que ella asistiera a clases diarias mientras que sus hijos recibían el beneficio de un ambiente escolar de más calidad. En este programa ella podía mejorar su estimación propia creando una red de personas con su mismo problema y trabajando activamente en el objetivo de mejorar su educación. Más aún, ella comenzó actividades con sus hijos que le facilitaba comunicarse emocionalmente con ellos mientras que aprendía como poder acelerar su desarrollo y prevenir más retraso en la habilidad verbal de sus hijos. El padre participaba también activamente en el Programa. Además de su compromiso de recibir terapia, él decidió ofrecer su habilidad de líder al Programa y ha asistido regularmente a todas las sesiones del Comité de Padres, en las cuales tiene una participación destacada. La participación del padre en el Comité de Padres lo está ayudando a satisfacer su necesidad de conectarse de nuevo con su familia y de crecer personalmente como líder y como miembro de la comunidad. Los tres niños asisten regularmente a clases para acelerar su desarrollo de acuerdo con sus respectivas edades. Aunque Carlos y José continúan aún teniendo retraso en la comunicación verbal, ellos han demostrado alguna mejora y Melanie se ha mantenido con un desarrollo apropiado en todos los aspectos, incluyendo dicción y vocabulario.

Para responder a todas las necesidades de la familia Martínez se necesita un grupo integrado para ofrecer los servicios requeridos. La Visitadora Social, al administrar apoyo y al responder a las necesidades educacionales iniciales de esta familia, consulta regularmente con los Coordinadores de los Programas de Desarrollo Infantil, Salud Mental, Servicios Sociales, y Health and Even Start. En las conferencias conjuntas de estos profesionales, donde se discute este caso, permiten que varias perspectivas se consideren en la evaluación de los problemas de la familia, particularmente con énfasis en los factores ambientales que pudieran afectar el desarrollo de la habilidad verbal de los niños. El consiguiente plan de servicios utiliza las muchas oportunidades que

existen en el Programa. La habilidad de la Visitadora Social en el manejo de este caso ayuda a los padres a trabajar sin dificultad alguna con el Centro Regional y el Distrito Escolar. Las intervenciones del Centro promueven el progreso emocional de la madre y el establecimiento de metas personales. Estas intervenciones también permiten a los niños socializar con otros niños en un ambiente positivo y estructurado y la madre puede presenciar muchos ejemplos de padres que se comunican emocionalmente de una forma positiva con sus hijos.

La experiencia del especialista en Desarrollo Infantil es utilizada en hacer más efectivo el método educacional durante las visitas al hogar de la familia y en las actividades conducidas en el Centro. Por último, los padres están recibiendo psicoterapia tradicional donde reciben ayuda en sus problemas matrimoniales y sus preocupaciones individuales. Todas las intervenciones tradicionales y no tradicionales responden a los problemas de relación, individuales y ambientales que el Grupo consideró como factores de salud mental que contribuyen significativamente al retraso en el lenguaje de los niños. Todos los miembros del Grupo están involucrados, no tan solo en las intervenciones relacionadas con la salud mental de la familia, pero también con las actividades relacionadas con su desarrollo educacional.

La familia Martínez continua participando activamente en el Centro Familiar Hope Street. Aunque los problemas de desarrollo y los más complicados asuntos familiares no se han resuelto completamente, ambos padres están comprometidos con el proceso de cura y reportan que nunca antes la familia se ha sentido tan estable y esperanzada en el futuro. Nosotros nos hemos dado cuenta mientras trabajábamos con la familia Martínez, y también con otras familias, que un aspecto esencial en el proceso de promover esperanza y motivación para cambios en el comportamiento, es que se ofrezca a las familias opciones que les permitan utilizar sus propias habilidades en el proceso de planear la manera de alcanzar sus metas. ♦

ORGANIZATIONAL ENVIRONMENTS THAT SUPPORT MENTAL HEALTH

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This essay is a synthesis drawn from presentations made by the authors at the October 2000 Infant Mental Health Forum.

Early Head Start and other community-based programs can offer infants, toddlers and their families a network of consistent, nurturing relationships. Such relationships can foster very young children's healthy social and emotional development by influencing the child directly, since everything that children learn about themselves as individuals and the way they make sense of their experiences are deeply rooted in the nature of their relationships with others. Strong early childhood programs can also influence other relationships – especially the relationship between child and parent. Program staff in many roles have unique opportunities to promote mental health, and to recognize and address mental health problems.

In order to realize their potential to contribute meaningfully and to the mental health of infants, toddlers, and families, the staff of community-based programs need to:

- Develop strong working relationships with parents;
- Pay attention to the physical and emotional quality of the environment;
- Work intentionally to support very young children's emotional regulation and emerging prosocial behavior;
- Recognize what they bring – in their professional roles and from their personal experience – to their work with infants, toddlers and families; and
- Give and get the kind and level of support that such intellectually and emotionally demanding work requires.

Three beliefs characterize an organizational culture that facilitates infant mental health:

1. Learning is a lifelong process.

2. Learning is reciprocal — everyone in an organization learns and develops together.
3. Relationships build over time, relying on accumulating trust and emotionally sensitive communications.

"Reflective practice" is a term that many people use to describe what programs do to actively embrace these beliefs – to establish and maintain an organizational culture that facilitates mental health.

Reflective practice can be described as the art of "stepping back" to examine what one is observing or doing (thus it requires a certain level of comfort with self-examination). It is a skill that takes time and ongoing support to develop and practice consistently. *Reflective supervision*, the availability of a *trained infant mental health specialist*, and appropriate *continuing education* are program elements that support reflective practice.

- **Reflective supervision** is an opportunity to reflect with another in order to grow professionally. In addition to *reflection*, supervision that supports reflective practice includes *collaboration* between supervisor and supervisee, so that power is mutually shared, and *regularity*, so that supervision become a predictable "oasis" of calm and thoughtfulness, free from intrusion or distractions, amidst the demands of daily work (Fenichel, 1992; Gilkerson & Shahmoon-Shanok, 2000). Reflective supervision encourages participants to see alternatives, plan activities, extend empathy, and build their capacity to support emotional regulation. Guided reflection also helps practitioners to make use of their experiences appropriately, while minimizing the influence of unexamined attitudes or "ghosts" from the conflicted past (Fraiberg, Adelson & Shapiro, 1975). In the process of repeated trial and error that all infant/family work

entails, reflective supervision – group or individual – allows practitioners to build competence as they share dilemmas safely with colleagues, preserving confidentiality and respecting other boundaries.

- **A trained infant mental health specialist** on-site in an Early Head Start program, child care center, or other community-based program is important for daily work and consultation with staff, as well as with families and children. In addition to conducting or overseeing reflective supervision an infant mental health specialist may:
 - engage in parental guidance and developmental counseling related to infant mental health;
 - screen and/or assess children for developmental delays, disabilities, and mental health problems and make referrals as necessary;
 - respond to emotion-based crises in children and families, and be available for short-term interventions;
 - support and mentor staff around mental health issues;
 - consult on matters of child protection and reporting of suspected abuse or neglect;
 - help staff understand the importance of relationships and relationship building, as well as the impact of disruptions in relationships;
 - observe, listen, and to some extent become immersed in program activities; and
 - on occasion, provide relationship-focused therapy with child and parent (Ervolina, personal communication).
- **Continuing education** to improve the mental health knowledge and skill of all staff of community-based infant/family programs should match local circumstances, local needs, and local opportunities. There must be cultural sensitivity, competence, and responsiveness to the traditions of the populations being served. Any "top-down" approaches to teaching infant mental health (for example, a "train the trainers" initiative at a national center) needs to be balanced with expert training on-site and in community-based contexts. If an infant mental health specialist is charged with much of the responsibility for continuing education of staff, the specialist must be prepared to address local problems and opportunities. For example, in one community, a number of young children and parents may be suffering from traumatic or post-traumatic stress disorder, and there may be an opportunity to join in a community-wide violence prevention initiative. At another site, parental depression, substance abuse, and family disorganization may be the focus of attention. Staff of one program may be most interested in learning how to structure the environment to facilitate self-regulation among infants and toddlers who are experiencing difficulty in this domain; at another site, the infant mental health specialist may be asked to train home visitors in interaction guidance (see Solchany & Barnard, this issue).

Two Models of Supervision That Supports Reflective Practice

In Italy, the community-based early childhood education approaches known as Reggio Emilia and those of related infant-toddler centers (Edwards, Gandini & Foreman, 1998; Gandini & Edwards, 2001) create environments in which parents, staff at all levels, and children are involved together in continuous learning and reflection. Learning is viewed as relationship based; each child is immersed in a network of carefully cultivated, emotionally warm and responsive relationships. Experiences of conflict and difference are valued as opportunities for discussion, repair of relationships, and reaching new points of view. All of this takes time: Teachers and other staff spend a major part of their time each week collaborating with others in mutual supervision and in critical discussions that are based on their experiences and observations. Thus supervision and monitoring are built into program culture, as helpful and important ways of putting into practice the belief that children, parents and staff are all learning and developing together.

The traditions of clinical mental health practice offer a second model of consultation, coaching, and reflective supervision. Clinical psychologists, psychiatrists, and social workers think of supervision as an individually tailored opportunity to learn. Supervision is a highly valued component of training and the early years of practice; even experienced mental health clinicians continue to seek supervision and consultation from colleagues. In mental health settings, a continuous atmosphere of mutual consultation and learning may begin with regularly scheduled opportunities for reflective supervision, but it also contains daily opportunities for mutual consultation among professionals as they confront the uncertainties and difficulties of mental health practice. This model recognizes that working with people who have mental health problems – adults or children – is likely to arouse discomfort and stir up one's own problems. The helper often needs the opportunity to gain perspective and support from others. An organizational environment that values communication and support among professionals, where all are learning together, can overcome the feelings of bewilderment, disorganization, and helplessness that often accompany work with suffering young children and families.

at a glance

- "Reflective practice" describes what programs do to establish and maintain an organizational culture that facilitates mental health.
- Reflective supervision, the availability of a trained mental health specialist, and appropriate continuing education are program elements that support reflective practice.
- An organizational environment in which all staff are learning together can overcome the painful feelings that often accompany work with suffering young children and families.

Reflective Environments in Early Head Start

At the Ounce of Prevention's Early Head Start program, which offers comprehensive home and center-based support, care and education for first-time pregnant teen parents, staff have distilled ten lessons from work over the course of the past six years. These lessons continue to provide a focus for training, practice, reflection, and planning for the future.

1. **Working toward the integration of Early Head Start and Head Start** (and other early childhood programs) recognizes the continuous development of young children's social and emotional competencies in the first five years of life. Well-planned transitions for children and training shared among early childhood programs are strategies for achieving this goal.
2. **A clear focus on development** – of both child and family — at formal staffings and team meetings leads to meaningful prevention and intervention planning. The developmental focus becomes the program's "north star."
3. **Training in observation** enables staff of home-based and center-based programs to capture meaning from interactions between parent and child, staff member and child, staff and family, and between children. Meaningful interactions are the basis for relationships; understanding them is thus essential to relationship-based practice.
4. **Intensified training on relationship building and interdisciplinary work** is important as community-based programs strive to become more comprehensive. Moving beyond discipline-specific traditions of communication, planning, and evaluation to a new, integrated vision takes time.
5. **The younger the child, the more critical it is to understand the family – the child's environment – in order to support healthy social and emotional development.** Family support staff in Early Head Start and other 0-3 programs should have the training and organizational support they need to understand participating families, in the context of culture and community, and communicate their understanding to other program staff. Such a change in EHS and birth-to-three programs will influence Head Start and other programs for preschoolers.
6. **Family support workers' case loads must be reduced** in order to build "deep" programs that can help families make changes in their lives, achieve goals and realize their dreams for their children.
7. **Infant mental health consultants should work with programs on a regular basis.** Children's social and emotional development needs ongoing regular attention. However, expert consultation is expensive, and in many communities may be difficult or impossible to find at any price. Increased financial support at the national level is needed to train infant mental health consultants and pay for their services.
8. **The basic qualifications – and job descriptions — for staff working with infants and toddlers in all capacities**

in programs that serve families with very young children deserve re-examination as our learning and expectations for very young children evolve. Program staff should ask themselves the same questions they ask parents: What are our hopes and dreams for the babies and toddlers that we serve? Then, what do we need in order to achieve our goals—and be accountable for child outcomes? Clearly delineated roles and areas of responsibility for staff supported by reflective supervision, are an important part of the answer.

9. **Programs serving infants, toddlers and their families are poised for a major shift.** Providing a nurturing, supportive, and restorative environment, rich with a range of experiences for all involved, requires a shift from a traditional classroom model to a comprehensive program that embraces families and their children. Expect resistance – it means that change is underway!
10. **Families and their children, from before birth to five years, need a seamless service delivery system.** Achieving this vision demands that community-based programs review and change their infrastructure, seek out and blend funding from both public and private sources.

Conclusions

If we really believe that everything children learn about themselves as individuals, and how they make sense of their experiences, are deeply rooted in the nature of their relationships with others, then programs designed to serve families with young children should reflect this belief in all that we do. This means creating – and sustaining — an organizational infrastructure sturdy enough to support reflective practice and reciprocal learning. To nurture our youngest children in networks of trustworthy, emotionally warm relationships, we must commit our resources – in community programs, and as a nation – to this goal. ♦

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**EARLY EDUCATION ADVOCACY
IN MINNESOTA**

To the Editor:

The June/July 2001 issue of *Zero to Three* on Babies, Practitioners, and Public Policy is a treasure – may I have two additional copies for women in leadership positions in the Minnesota Legislature – a Senator and a Representative?

I also thought readers of *Zero to Three* might be interested in knowing that the information I gained at the 2000 National Training Institute provided a good foundation for the current data I use in visits to the Legislature; I know which experts I want to keep up with!

Minnesota's legislative session was a big disappointment to advocates for children, but I've kept on advocating at the state level and with Minnesota's Congressional delegation on behalf of paid parental leave, the Earned Income Tax Credit, and the restoration of surplus food commodities to home day care providers. Closer to home I've been working with a task force of the Highland-MacGroveland Family Center, part of the Children's Initiative in St. Paul, trying to put in place child care for service workers from all over the world who work difficult hours for minimal pay. I'm also

participating in the Workforce Development Committee of the Midway Chamber of Commerce, which serves the area linking the Twin Cities' commercial areas; the Committee continues to study paid parental leave.

The delicate balance here is keeping my day job (22 hours/week as a child care provider, so I can retain health insurance) while having enough hours in the week to accomplish credible work in these other areas.

Elin Mahnquist Skinner
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Editor's Note: The writer was a recipient of an Emily Fenichel scholarship to ZERO TO THREE's 2000 National Training Institute.

**THE RELATIONSHIP BETWEEN ABUSE,
NEGLECT, EMOTIONAL PROBLEMS AND
DEVELOPMENTAL DELAY**

To the Editor:

My congratulations to you for printing the outstanding article, "Innovations in Assessing and Helping Maltreated Infants and Toddlers in a Florida Court" by Cindy Lederman and Sandra Adams (*Zero to Three*, June/July 2001).

As a professional working in the field of abuse and disabilities, I have

not read an article which more clearly states the relationship between abuse and neglect and the emotional problems and developmental delays that many children experience. If this relationship were more clearly understood, funding for programs for young children would become a national priority. In addition, legal and investigative agencies would understand the mandate to properly investigate charges of abuse and neglect against young children instead of dismissing them on the basis that the child is too young to testify. The changes in the court system, the insight of the authors, and the recognition of the need for early treatment are inspiring. I hope *Zero to Three* continues to explore this topic and provide leadership on this topic.

Judith A. Allen, MS, LPC
Chicago Children's Advocacy Center
Metro Chicago Coalition on
Abuse and Disabilities

Editor's Note: ZERO TO THREE's 2001 National Training Institute will feature a number of presentations on the development of infants and toddlers in the child welfare system, and the February/March 2002 issue of *Zero to Three* will also explore this issue.

PUBLICATIONS

**The Power of Questions:
Building Quality Relationships with Infants and Families**

(2001) Rebecca Parlakian
(ZERO TO THREE, 2000 M
Street, NW, Suite 200, Washington,
DC 20036, www.zerotothree.org)
\$7.50.

This publication explores how leaders and staff can use reflective approaches to establish effective working relationships with families.

The publication offers guidelines for good relationships with families, suggestions for setting and explaining boundaries, ethical guidelines for work with families, and steps in managing reactions to individuals and families.

**Look, Listen, and Learn:
Reflective Supervision and
Relationship-Based Work**

(2001) Rebecca Parlakian
(ZERO TO THREE, 2000 M

Street, NW, Suite 200, Washington,
DC 20036, www.zerotothree.org)
\$10.00.

Part of a series of publications designed as resources for program leaders, developed by staff of ZERO TO THREE's Center for Program Excellence, this 19-page publication explores the link between supportive supervisory practice and effective staff-parent relationships. The publication describes relationship-based organizations and offers a "look, lis-

ten, and learn" approach to reflective supervision with direct service and administrative staff in programs serving families with infants and toddlers. Guidelines for initiating, managing, and institutionalizing the changes required to build a relationship-based organization are also provided.

Being in Charge: Reflective Leadership in Infant/Family Programs

(2001) Rebecca Parlakian and Nancy L. Seibel, M.Ed., NCC (ZERO TO THREE, 2000 M Street, NW, Suite 200, Washington, DC 20036, www.zerotothree.org) \$7.50. (prepublication price).

Being in Charge explores the experience of being a new leader in an infant/family program. Specifically, it describes how to use self-awareness, observation and flexible responses as tools to manage stress and increase on-the-job effectiveness. A number of leadership issues are discussed, including: how to individualize one's relationships with staff members, encourage collegial work, and learn from conflict. Ideas presented are applicable to a wide range of infant/family settings. The publication includes interactive group exercises and a self-assessment of leadership style.

Covering Intensive Community-Based Child Mental Health Services Under Medicaid

(2001) Bazelon Center for Mental Health Law (Bazelon Center for Mental Health Law, 1101 15th St. NW, Suite 1212, Washington, DC 20005) \$10.00.

This packet highlights how programs may secure Medicaid coverage for six services (behavioral/therapeutic aides, intensive at-home services, child respite care, after-school programs, therapeutic summer camps, therapeutic nurseries and preschools) that support children with serious mental or emotional disorders and their families. The six issue briefs in

the packet each include a description of the profiled service, references to research supporting its effectiveness, and composite definitions drawn from various states' federally approved use of Medicaid to cover delivery of the service.

Funding Early Childhood Mental Health Services & Supports

(2001) Georgetown University Child Development Center (Georgetown University Child Development Center, 3307 M Street NW, Washington, DC 20007-3935) This publication outlines a range of funding sources for children's mental health services and supports; these are organized under four general categories: prevention and early intervention, clinical services, community services, and family and caregiver support services. Major federal, state, local government, and non-government funding sources are synopsized, with each profile providing information on issues such as covered services and activities, applicant eligibility, beneficiary eligibility, and flow of funds.

Ending Welfare as We Know It

(2000) R. Kent Weaver (Brookings Institution Press, Dept. 029, Washington, D.C. 20042-0029/www.brookings.edu). Hardcover - \$44.95; paper - \$19.95 + \$4.00 shipping for first book; \$0.50 for each additional.

This book analyzes the political history of changes in the AFDC program, particularly the national welfare reform legislation enacted in 1996, and examines how broad societal forces and political institutions interacted with short-term political and policy calculations to shape policy-makers' decisions. More generally, the author argues that the bargaining that characterizes welfare reform reflects central features of American politics that affect the formulation of all social policy. The book offers a brief introduction to the problem of

child poverty in the United States and programs intended to help poor families, showing how different approaches to welfare reform differ in their diagnoses of the causes of poverty and the proposed solutions that flow from those understandings. Weaver examines how social research creates the policy context for reform, and he discusses the important role of interest groups and governors, President Clinton's role during the 1990s, and the course Congress followed in passing welfare reform legislation. His analysis argues that new legislation neither settled the direction of welfare reform nor depoliticized it; many issues will be debated again when the TANF program is considered for reauthorization in 2002.

The Parent to Parent Handbook: Connecting Families of Children with Special Needs

(2001) Betsy Santelli, Florene Stewart Poyadue, Jane Leora Young (Paul H. Brookes Publishing Co., Inc., P.O. Box 10624, Baltimore, MD 21285-0624/www.brookespublishing.com/ 1-800-638-3775). Paper - \$29.95.

Over the past 30 years, awareness has increased of the need for experienced parents of children with special needs to provide informational and emotional support to parents who are new to the challenges of caring for a child with a disability. This book provides the rationale for parental support through stories by and about families, and it explains the network of Parent to Parent programs that match parents of children with similar disabilities in one-to-one relationships. Drawing on research about best practices in program development and training, the authors offer concrete advice about creating and sustaining Parent to Parent groups. They present guidelines for finding, preparing, and matching supporting parents with newly referred parents, as well as ideas for organizing, incorporating, funding, promoting, and evaluating a program.

It also includes forms and extensive lists of contacts and resources to help local programs get started. The practical tools in this handbook, such as how to organize and institutionalize a program, are also applicable to many other community-based programs.

In Time and With Love: Caring for Infants and Toddlers With Special Needs, Second Edition

(2001) Marilyn Segal (Newmarket Press, 18 East 48th Street, New York, N.Y. 10017/www.newmarketpress.com, Paper - \$18.95 + \$3.00 shipping and handling for the first book and \$1.00 for each additional copy.

Drawing on the experience and expertise of 36 families, as well as that of child development specialists, this book is designed to help parents deal effectively with the particular issues of rearing children with special needs. Illustrated with numerous photographs, it is written for parents who are concerned about their baby's development, to help them mobilize their resources and build on the strengths of their baby, even when there are no clear answers. Section I addresses the emotional ups and downs that families experience as they care for their baby with special needs, as well as the importance of maintaining relationships with family and friends despite the time and energy devoted to baby care. Section II focuses on the importance of daily routines to learning each baby's cues and engaging in intimate communication. Section III describes ways of stimulating each baby's growth in different developmental domains and suggests ways of adapting activities to a baby's special needs. Section IV underscores the importance of playful parent-baby interactions. Section V describes difficult decisions parents often face and discusses pros and cons involved in making choices about having additional children, returning to paid employment, and arranging

child care. Guidance is offered for making informed choices about specialists, developing relationships with professionals, and coping with illness and hospitalization. Advice is also presented to help parents serve as a child's advocate and plan for the future.

The Ordinary Is Extraordinary: How Children Under Three Learn

(Reissued electronically, 2001) Amy Dombro and Leah Wallach. Available at iuniverse.com and at major on-line bookstores including Amazon.com and Barnesandnoble.com, \$19.95.

As many parents today feel pressured to spend "quality time" preparing their infants and toddlers for success in school and life, this book shows parents how and why the ordinary, everyday moments they share with their children can be the most valuable educational activities of all. Dombro and Wallach explain how young children learn and how, by looking at the world through their children's eyes, parents can become more aware of the learning process.

They present scenes from everyday life of three diverse, fictional families to reveal the untapped possibilities offered while, for instance, preparing and eating dinner, dressing a child, changing a diaper and taking a neighborhood walk.

Watch Me Grow: I'm Two

(2001) Maureen O'Brien with Sherill Tippins (William Morrow/HarperCollins Publishers, 10 East 53rd Street, New York, N.Y. 10022/www.harpercollins.com). Hardcover - \$18.95.

Because advice to parents is rarely tailored to the needs or circumstances of their unique child, the *Watch Me Grow* series is designed to show parents how to observe the ways their child's developmental level, emotional needs, and unique personality fit or clash with those of her caregivers. To

provide a foundation for effective parenting strategies, *I'm Two* discusses the growth of the child aged 24 to 36 months, particularly toddlers' predictable "declaration of independence" from their parents. The authors, one of whom is a consultant to the Brazelton Touchpoints Center, take parents through practical, everyday situations, showing how patience, reasonable expectations, consistent rules, and a sense of humor allow families to grow together with understanding, excitement, and joy. Chapters focus on two-year-olds' physical abilities, cognitive development, verbal abilities, social and emotional growth, and need for limits and routine, as well as what parents can expect in their child's fourth year. Discussion focuses on typical development, with suggestions for parents who are concerned about developmental delays.

Biobehavioral Assessment of the Infant

(2001) Lynn Twarog Singer and Philip Sanford Zeskind, editors (Guilford Publications, 72 Spring Street, New York, NY 10012) \$60.00.

This volume is designed to provide a source that describes the historical, diagnostic, methodological, and conceptual utility of tools used to assess the biobehavioral integrity of the newborn and young infant, and their implications for understanding the development of the infant at risk. (The term "biobehavioral" is used to emphasize the biological basis of behavior within a given environmental context.) Chapters in the volume explore assessments that vary in age appropriateness (from prenatal period to one year), level of analysis (from cortical electrophysiology to infant attachment), and technological advancement (from well-established tests of sensorimotor skills to more recent measures of neurobehavioral function). Issues addressed include prenatal growth and sensory development, arousal and regulation, and

learning and attention. Each contributor has been asked to discuss what a particular measure tells one about development, and why. In addition to the editors, contributors include, among others, Nathan Fox, Susan Goldberg, Megan Gunnar, Anneliese Korner, Barry Lester, Michael Lewis, Evelyn Thoman, and Edward Tronick.

Handbook of Developmental Cognitive Neuroscience

(2001) Charles A. Nelson and Monica Luciana, editors (The MIT Press, 5 Cambridge Center, Cambridge, MA 02142-1493/<http://mitpress.mit.edu>). Hardcover - \$95.00.

Brain imaging and other technological advances are yielding methods that can be used safely to study brain structure-function relations and their development in children, but public enthusiasm for what brain science might mean for parenting and early childhood often outpaces scientific understanding. This handbook provides a starting point for exploring the implications of recent research that uses the techniques of both brain science and cognitive science to explore the biological foundations of human cognition. It includes 41 original contributions that show how scientists have begun answering fundamental questions about interactions between emotion and cognition, how they explore the biology of cognition, and how such phenomena relate to human behavior. Aided by recent findings that the human brain remains malleable and plastic throughout much of the lifespan, the authors also begin to explore the implications of lifelong neural plasticity for brain and human development. The book includes sections on the basic principles of neural development, the methods that clarify brain-behavior relations in the context of cognitive development, the development of sensory and sensorimotor systems and language, the

development of various cognitive domains, and neurodevelopmental aspects of clinical disorders.

VIDEOTAPES

Family Affair: Educating Today's Parents.

Produced by Stephen Onda and Will Dixon. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel: 800-405-8942. Fax: 818-994-0153. 25 min. \$100 plus shipping and handling.

In this video parents and parent educators describe their experience with a Learner-Centered Model for parent support and learning. The program looks at several different families coping with typical parenting situations; the parent group provides an opportunity for them to share their experiences and to realize that they are not alone in their problems. Through the group experience, parents learn how to increase their choices in making parenting decisions, how to get help before a problem develops, and how to negotiate with their children by including their input in the decision-making process.

The Healing Cycle: Infants in Recovery.

Produced for Epiphany Early Intervention Training Program (a program of Mt. St. Joseph - St. Elizabeth), San Francisco, CA. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel: 800-405-8942. Fax: 818-994-0153. 19 min. with accompanying training handbook. \$85 plus shipping and handling.

In this tape child development professionals describe and demonstrate a healing environment for infants prenatally exposed to drugs, alcohol, and other substances. This therapeutic environment includes listening and communicating, touching in a comforting way, changing the environment, creating physical securi-

ty, and developing healthy movement patterns. Caregivers who create this environment tend to become more aware and respectful of individual personalities. Children who know they are unconditionally loved and respected are able to grow up with healthy levels of confidence and self-esteem.

The High/Scope Approach for Under Threes.

U.S. Edition. Produced by High/Scope U.K. Available from High/Scope Press, 600 N River St., Ypsilanti, MI 48198-2898. Tel: 800-407-7377. Fax: 800-422-4329. Web site www.highscope.org. 68 min. \$55 plus shipping and handling.

The High/Scope approach focuses on the active natural desire of children to learn. This video, filmed in the United Kingdom, shows caregivers interacting with infants and toddlers to support and extend their active learning explorations and discoveries. Three basic principles are fundamental to this approach: 1) children need to form close relationships with adults based on trust and mutual respect; 2) they need an environment in which key learning experiences can take place; and 3) they benefit significantly from being able to think and act on their own initiative. The video illustrates strategies that caregivers can use in the environment, daily activities, close relationships, and in evaluating progress and planning further work to support the active learning of infants and toddlers.

Life's First Feelings.

Produced by James Lipscomb and Bill Wander. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel: 800-405-8942. Fax: 818-994-0153. 60 min. \$75 plus shipping and handling.

This 1986 video examines research techniques that open a window on infant emotions and allow scientists to explore the inner workings of a child's world. The program provides evidence that emotions serve

important biological and social functions in the development of a child's personality. The work of Spitz, Tronick, Izard, Kagan, Campos, Emde, Klinnert, Lewis, Yarrow, and Greenspan is presented. The video seeks to show that infants begin life with a set of survival-oriented emotions and acquire social emotions as they pass through childhood.

Mental Health in Head Start: It's Everybody's Business.

Discussion guide available. Also available in Spanish. Produced for the Head Start Bureau and available from Head Start Publications Management Center, P.O. Box 26417, Alexandria, VA 22313-0417. Tel: 202-737-1030. 18 min. \$5 for videotape and \$2.50 for the 19-page discussion guide.

This videotape provides an overview of the mental health program in Head Start. The program focuses on the promotion of positive mental health practices for children, families and staff. The video is divided into five sections: (1) What is Mental Health? (2) Overview of Mental Health in Head Start; (3) Incorporating Mental Health Practices into the Classroom; (4) Mental Health for Parents; and (5) Mental Health for Staff. The discussion guide reviews the contents of the video and offers suggestions on how to introduce and discuss it with various audiences.

Mental Health in Head Start: A Partner for Families.

Discussion guide available. Produced for the Head Start Bureau and available from Head Start Publications Management Center, P.O. Box 26417, Alexandria, VA 22313-0417. Tel: 202-737-1030. 28 min. \$5 for videotape and \$2.50 for 20-page discussion guide.

This video is designed for parent group meetings. The families in the video represent many of the cultural and ethnic backgrounds of Head Start families throughout the country.

They live in cities and rural areas with many different family situations, issues, and concerns. Some of the topics discussed include building self-esteem, communication, discipline, violence, disabilities, parenting styles, asking for help as a sign of strength, and stress and reactions to it. The program offers an understanding of what mental health means and how everyday behavior and parenting styles affect the mental health of both parents and their children. The discussion guide offers methods for leading effective group discussion.

The Most Important Baby in the World: The First Year of Life.

Includes eight tapes and seven accompanying books. Produced by My Baby-U. Available from Child Development Media, Inc., 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel: 800-405-8942. Fax: 818-994-0153. \$75 each program, \$420 for the series plus shipping and handling.

Designed as a self-teaching, at-home program for new parents and other infant caregivers, but also appropriate for parent groups, child care providers, and students of infant development, this series aims to enable new parents to become more knowledgeable, observant, and responsive to their infants' cues and individual learning abilities. The series focuses on eight babies and their families throughout the first year and includes dialogue between parents and various infant development experts. A National Institutes of Health study evaluating the effectiveness of the series by comparing mothers who participated in viewing the materials with non-participating mothers found that participating mothers significantly increased their knowledge of infant development and were more pro-active with regard to infant medical care; their infants had significantly fewer severe illnesses during the year. Introduced by T. Berry Brazelton, the series also includes the contributions of Kevin Nugent, Richard Ferber, Tiffany Field, and

Barry Lester. Programs include *As a Newborn* (53 min.), *At One Month* (51 min.), *Enjoying Infant Massage* (12 min.), *At Three Months* (50 min.), *At Five Months* (66 min.), *At Seven Months* (55 min.), *At Ten Months* (51 min.), and *At One Year* (67 min.).

Young Children in Brief Separation.

Produced by James and Joyce Robertson, London, England. Distributed by Child Development Media, 5632 Van Nuys Blvd, Suite 286, Van Nuys, CA 91401. Tel: 800-405-8942. Fax: 818-994-0153. Filmed between 1967 and 1971, in black and white, by James and Joyce Robertson. \$100 each program, \$450 for the series plus handling and shipping.

This classic five-film series deals with the responses of healthy young children to separation from their mothers. The Robertsons observed in detail the behavior of five children, ages 1 to 2, whose mothers were hospitalized, for 9 to 27 days, for the birth of a new baby. John, age 17 months, was placed in a residential nursery where his mothering needs were not met. The non-verbal cues he offered for attention were not understood by the nine nurses, who changed frequently. In an institutional setting, which imposed many stresses in addition to the separation from his mother, John became overwhelmed by despair, and when he was reunited with his mother, he rejected her. Jane, Lucy, Thomas and Kate were cared for in the Robertson family home by a fully available foster mother (Joyce Robertson). Unlike John, they did not become acutely distressed. They were held in a state of "manageable anxiety" and returned to their mother with pleasure and warmth. Each film is a complete study and may be used on its own. The films, as a series, complement each other by showing how the young child's ability to cope with separation from the mother is affected by age, level of maturity, the parent-child relationship, and the quality of substitute care. The programs include John, 17

months, *Nine Days in a Residential Nursery* (43 min.); Jane, 17 months, in *Foster Care for 10 Days* (37 min.); Lucy, 21 months, in *Foster Care for 19 Days* (31 min.); Thomas, 2 yrs and 4 months, in *Foster Care for 10 Days* (38 min.); and Kate, 2 yrs, 5 months, in *Foster Care for 27 Days* (33 min.).

ON-LINE RESOURCES

Correction: The correct web site address for the Center for Early Childhood Leadership, National-Louis University, described in the June/July 2001 issue of *Zero to Three*, is www.nl.edu/cecl.

Questions About Kids

www.harristrainingcenter.org

Questions About Kids are short, easy-to-read two-page flyers that provide answers, based on current information about the psychological development of infants and toddlers, to such questions as: How can parents and caregivers support a baby's healthy development? How do I get to know my newborn? What's going on in my baby's brain? What does it mean when my young child is "assessed"? How can trauma affect my young child? Do dads really make a difference? Am I spoiling my baby? and, How can I help my young child to become a reader?

The flyers have been written by child development experts at the University of Minnesota and in the community for use by parents and professionals. Some of the flyers are available in Spanish, Hmong, and Somali as well as English. They can be downloaded and reproduced with no copyright restrictions.

Bright Futures

www.brightfutures.org

The National Center for Education in Maternal and Child Health (NCEMCH) has redesigned the web site for its Bright Futures campaign. The site now features an HTML version of *Bright Futures: Guidelines for Health Supervision of Infants, Children,*

and Adolescents. Electronic copies of other publications, including six-page tip sheets for families, can be downloaded as PDF files. The release of *Bright Futures in Practice: Mental Health* is anticipated shortly.

America's Children: Key National Indicators of Well-Being 2001

<http://childstats.gov>

This fifth report in an annual series prepared by the Federal Interagency Forum on Child and Family Statistics is a collaborative effort by 20 Federal agencies. It covers population and family statistics and indicators of children's well being related to economic security, health, behavior and social environment, and education. The report notes, for example, that in 1999 children from birth through age 2 were more likely to be in home-based care, either with a relative or nonrelative (41 percent), than to be in center-based care (16 percent). Children under age 6 are more likely to be living in families with incomes below the poverty line than children ages 6 to 17 (18 percent vs. 26 percent).

The Commonwealth Fund publications on child health and development

www.cmwf.org/programs/child

In connection with its grantmaking to improve health care policy and practice, the Commonwealth Fund issues more than 50 reports each year on a variety of topics. The online publications area allows users to view a list of relevant publications, read summaries, and register to receive e-mail alerts when new publications become available. A May 2001 publication in the Child Health and Development program area is *No Place Like Home: State Home Visiting Policies and Programs* by Kay Johnson, based on a survey of states with child home visiting programs aimed primarily at low-income families. The report notes that child advocates and state officials have often promised greater results from home visiting services than can be

achieved; it recommends that states establish a continuum of early childhood services addressing a wide range of needs, from pregnancy planning and prenatal services to infant assessments and parent education. It calls for greater emphasis on quality and for new mechanisms to improve interagency coordination.

Foundation for Child Development Working Paper Series

www.fcd.org

The purpose of the Foundation for Child Development's Working Paper Series is to "share ideas and potential solutions about how all American families can meet the basic requirements for the healthy development of their children." Views expressed in each paper are those of the author(s). Titles currently available for downloading from the FCD website include, among others: *Regulation: An Imperative for Ensuring Quality Child Care* by Harold Gazan, *Why Are Early Education and Child Care Wages So Low? A Critical Guide to Common Explanations* by Julie Nelson, and *Let the War on the Poverty Line Commence* by Jared Bernstein.

Samuel J. Meisels, President of ZERO TO THREE, will become the next president of Erikson Institute in Chicago – the sixth person to lead Erikson since it was established in 1966 “to create a multiethnic, interdisciplinary group of child development leaders committed to educating the whole child.” Having earned his master’s and doctoral degrees in education from Harvard University, Meisels was most recently professor and research scientist at the University of Michigan’s School of Education. Erikson offers three master’s programs, a doctoral program (in collaboration with Loyola University Chicago), and a bachelor’s program (in collaboration with Columbia College Chicago).

Kathryn E. Barnard, past President of ZERO TO THREE and currently Co-Chair of its Diagnostic Classification Task Force, will head the University of Washington’s new Center on Infant Mental Health and Development, established through a partnership between the University’s Center on Human Development and Disability and School of Nursing, Department of Family and Child Nursing. The Center’s mission will include both research and training. The Center’s two-year Certificate Program in Infant Mental Health will train specialists to support the healthy emotional and mental development of infants and their families through direct service and consultation to professionals in related fields. Training will involve seminar and lab participation, conducting clinical assessments, responsibility for up to three ongoing clinical cases, ongoing reflective supervision, and a field placement with a human services agency. **Donna R. Weston** (drweston@u.washington.edu), a ZERO TO THREE Graduate Fellow, will direct the Center’s training program.

Several ZERO TO THREE staff members are pursuing advanced training in a range of disciplines.

- **Julia Beckwith**, Project Director of ZERO TO THREE’s National Training Institute, has entered the Master’s Degree program in Social Work at the National Catholic School of Social Service at the Catholic University of America, Washington, DC.
- **Elizabeth Ford**, Director of ZERO TO THREE’s Cornerstones Project, has begun her doctoral studies at the Union Institute in Cincinnati, OH. She is pursuing a Ph.D. in Interdisciplinary Arts and Sciences with an emphasis on Child and Family Studies.
- **Erica Lurie-Hurvitz**, Director of Public Policy at ZERO TO THREE, is beginning studies at the Georgetown University School of Law, Evening Division.
- **Nancy Guadagno**, Director of Publications at ZERO TO THREE, is beginning part-time Master’s-level studies in infant special education at the George Washington University Graduate School of Education and Human Development. She has been awarded tuition support through the School’s Low-Incidence Disabilities Project.
- **Nancy Seibel**, Director of ZERO TO THREE’s Center for Program Excellence, is enrolled in the Graduate School of Education’s doctoral program at George Mason University. She has been awarded a High Potential Student Fellowship.

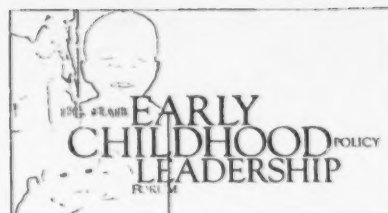
Several foundations have provided generous support to ZERO TO THREE in recent months.

- An anonymous foundation has joined the **Freddie Mac Foundation** with a second year grant of \$50,283 for the

Cornerstones Project. This grant will support Phase Two activities of leadership development, consultation, and training to programs in the greater Washington metropolitan area that serve families with young children.

- The **Atlas Family Foundation** has awarded a grant of \$50,000 to build ZERO TO THREE’s publications capacity. Funds will enable the organization to assess and strengthen its materials, adapt them for a variety of audiences, and market and disseminate efficiently and broadly.
- ZERO TO THREE has received grants from **The Atlantic Philanthropies** (\$50,000); the **Howard Heinz Endowment** (\$50,000); the **A. L. Mailman Family Foundation** (\$30,000); and the **Conrad N. Hilton Foundation** (\$17,000) to support the development of a new publication, *Early Head Start: Beacon of Hope for America’s Youngest Children*. This book will promote the vision of Early Head Start, celebrate its successes and document lessons learned.
- **Lucent Technologies** has joined the **John D. and Catherine T. MacArthur Foundation** with a grant of \$50,000 to support the creation and management of the State Early Childhood Policy Leadership Forum, sponsored by ZERO TO THREE working in partnership with the National Governors Association Center for Best Practices. For more information on the Forum see p. 77.
- The **A. L. Mailman Family Foundation** has awarded a \$15,000 grant to ZERO TO THREE to support development of the *Better Baby Care* web site (www.betterbabycare.org) to help promote better care for very young children.

THE ZERO TO THREE/NATIONAL GOVERNORS ASSOCIATION STATE EARLY CHILDHOOD POLICY LEADERSHIP FORUM



ZERO TO THREE and the National Governors Association (NGA) Center for Best Practices announce the creation of the State Early Childhood Policy Leadership Forum, a unique 18-month fellowship for innovators in state early childhood policy. The State Early Childhood Policy Leadership Forum is supported by the John D. and Catherine T. MacArthur Foundation and Lucent Technologies Foundation.

The 14 Leadership Forum Fellows are state-based policy and program leaders who serve in a variety of positions. As Forum participants, they will discuss ideas and share lessons learned with the goal of improving policy and program strategies to support young children and their families. The Forum will help Fellows build leadership skills so they can strengthen states' abilities to improve programs. During the Forum, the Fellows will take part in several retreats with key experts on early childhood issues and will be given the chance to discuss cutting-edge topics and learn from each other in a supportive environment. In addition to the retreats, Fellows will contribute to some of their own time to support newly emerging leaders and promote cross-system early childhood policies and programs. Activities may include contributing to national publications, presenting at conferences, identifying unmet technical assistance needs for national organizations and federal agencies, and reviewing efforts to translate new research about early childhood development into practical, effective practices and policies. An outgrowth of the Forum's activities will be a series of "lessons learned" publications that will be shared with policy leaders in all 50 states, to benefit programs serving young children.

The State Early Childhood Policy

Leadership Forum Fellows are policy and program leaders serving in a variety of positions. They include:

MS. LYNN N. FALLIN
Special Assistant, Children,
Youth and Families
*Office of the Governor
Honolulu, Hawaii*

Ms. Fallin has played a leadership role in both the state Interdepartmental council and the public-private Good Beginnings Alliance, two coordinating bodies responsible for the creation of Hawaii's integrated early childhood system.

MS. OXANA GOLDEN
Director, Division
of Child Care
*Colorado Department of Human Services
Denver, Colorado*

Ms. Golden leads the Consolidated Child Care Pilot initiative, which combines Head Start, the state-funded preschool program, and the Child Care and Development Fund subsidy program to provide full-time, full-year quality child care in local communities.

MS. ANNE R. HARNISH
Assistant Director
*Ohio Department of Health
Columbus, Ohio*

Ms. Harnish has led the development of "Help Me Grow," an initiative that creates a central point of communications and public awareness and integrates Ohio's home visiting, early start, and early intervention programs.

DR. JANE I. HENDERSON
Executive Director
*California Children and
Families Commission
Sacramento, California*

Dr. Henderson is the first Executive Director of the California Children and Families Commission, which oversees the implementation of Cali-

fornia Proposition 10, a \$700 million funding stream to promote school readiness at the local level.

DR. BEVERLY ROBERSON JACKSON
Director
*District of Columbia Head Start State
Collaboration
District of Columbia*

As the District of Columbia Head Start State Collaboration Project Director, Dr. Jackson is currently working to coordinate the work of Early Head Start, Healthy Start, Healthy Families DC, and private hospital home visiting programs.

DR. CHERYL MITCHELL
Deputy Secretary
*Agency of Human Services
Waterbury, Vermont*

Within Vermont's umbrella Agency of Human Services, Dr. Mitchell promotes cross-system policy development for the state Departments of Health, Developmental and Mental Health, Child Welfare, Social Welfare, Child Support, Corrections, Aging and Disabilities.

MR. CECIL J. PICARD
State Superintendent
of Education
*Louisiana Department of Education
Baton Rouge, Louisiana*

Universal access to quality early childhood education is at the forefront of Superintendent Picard's agenda. Under his leadership, Louisiana has established the First Summit on Young Children, and begun a pilot public school early childhood program.

MS. KAREN W. PONDER
Executive Director
*North Carolina Partnership for Children
Raleigh, North Carolina*

Ms. Ponder has worked with Smart Start, North Carolina's statewide comprehensive early childhood initiative

since 1993 and currently directs the nonprofit agency created by state legislation to administer Smart Start.

Ms. MARIE-LOUISE RAMSDALE
Director

*South Carolina First Steps to School
Readiness
Columbia, South Carolina*

First Steps works in partnership with local and state-level agencies and organizations – for example, the creation of a grants program for local early childhood initiatives with the Department of Social Services.

Ms. ELISABETH SCHAEFER
Administrator, Early Learning Services

*Massachusetts Department of Education
Malden, Massachusetts*

Ms. Schaefer guided the development and administers the Massachusetts Family Network, Community Partnerships for Children, and Full-Day Kindergarten Grants – elements

of a developing system of programs and services for young children and their families.

Ms. ELIZABETH TAFF-HOSP
Director

*Alabama Office of School Readiness,
Department of Children's Affairs
Montgomery, Alabama*

Ms. Taff-Hosp helped pass legislation for and develop the Office of School Readiness. In one year, she secured public/private funding for 8 pre-kindergarten pilot sites, soon to be expanded to 43 sites.

Dr. KIM F. TOWNLEY
Executive Director
*Office of Early Childhood Development
Frankfort, Kentucky*

Dr. Townley has led a multi-tiered effort to develop a comprehensive 20-year plan for early childhood for the State of Kentucky, culminating in passage of KIDS NOW legislation in April 2000.

Ms. NANCY L. VONBARGEN
Division Administrator

*Oklahoma Department of
Human Services
Oklahoma City, Oklahoma*

Ms. VonBargen is the first administrator of the Division of Child Care in Oklahoma, which, among other initiatives, has launched the TEACH scholarship program and the REWARD wage supplement program.

Ms. MARGERY WALLEN
Program Advisor

*Office of the Governor
Chicago, Illinois*

Ms. Wallen advises the Governor's 33-member Task Force on Universal Access to Preschool, which is developing a 5-year plan for achieving quality early childhood opportunities for all 3-5 year olds.

For more information on the Forum, visit www.zerotothree.org/policy/forum.html.

MENTAL HEALTH RESOURCES FROM ZERO TO THREE

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) (#113)

ZERO TO THREE's Diagnostic Classification Task Force, co-chaired by Stanley I. Greenspan and Serena Wieder \$25

The product of an 8-year effort, *DC: 0-3* gives clinicians and researchers a comprehensive, multi-axial framework for diagnosing emotional and developmental problems in the first three years of life. *DC: 0-3* is based on a new understanding of emotional, social, intellectual, motor, and sensory patterns in infancy and makes it possible to pinpoint very young children's adaptive capacities as well as their emotional and developmental difficulties. *Cited in this issue of Zero to Three*

How You Are Is As Important As What You Do...in making a positive difference for infants, toddlers and their families (#175)

Jeree H. Pawl and Marie St. John \$10

For use in training and ongoing professional development, *How You Are* contains a series of vignettes, dialogues and brief scenarios that can be used in group care, home-visiting programs, and infant mental health settings. The materials illustrate the overall theme that *how* parents and professionals interact with babies and young children, and with each other, contributes as much to the quality of the relationships involved and the developmental outcome as what is done in the interaction.

Learning through Supervision and Mentorship to Support the Development of Infants, Toddlers and Their Families: A Sourcebook (#71)

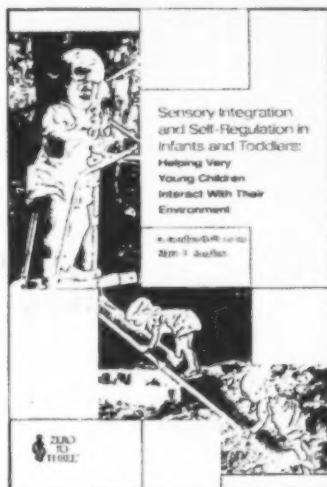
Emily Fenichel, Editor, with the ZERO TO THREE Work Group on Supervision and Mentorship \$18.95

Fondly known as the "Yellow" Book, *Learning Through Supervision and Mentorship* shows how mentoring and supervision can be the basis of relationships that provide regular opportunities for joint reflection upon work with young children and their families. It identifies the three elements central to successful supervision in infant/family programs and provides 18 chapters that paint a clear and comprehensive picture of supervision and mentorship of students and practitioners, and identify issues for supervisors. *Cited in this issue of Zero to Three*

For more information on these and other resources for Infant Mental Health, please visit our online bookstore at <http://www.zerotothree.org/bookstore.html> or call us at 1-800-899-4301.

STIMULATE YOUR SENSES

SENSORY INTEGRATION AND SELF-REGULATION IN INFANTS AND TODDLERS:
HELPING VERY YOUNG CHILDREN INTERACT WITH THEIR ENVIRONMENT



Every child has a unique pattern of taking in and responding to information from the senses. This new book, by G. Gordon Williamson and Marie E. Anzalone, is written for everyone who helps young children interact with their environments. The authors synthesize current thinking from a variety of fields about the sensory and motor development of infants and toddlers. Professionals from the therapeutic, medical, educational, mental health, and psychosocial fields all will benefit from the practical approach the book takes in describing:

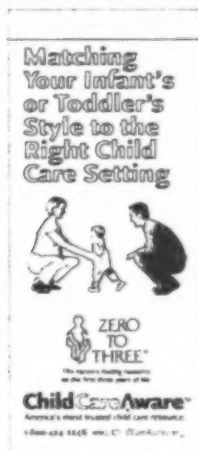
- sensory development of infants and toddlers;
- assessment and intervention methods that promote self-regulation and adaptive behavior; and,
- new directions and outstanding questions in basic and applied research in this field.

To order, please call (800) 899-4301 or visit the ZERO TO THREE on-line bookstore at www.zerotothree.org.

Publication #243, 130 pages, ISBN 0943657-067, \$22.50.

Now Available:

Matching Your Infant's or Toddler's Style to the Right Child Care Setting



Adapted by Rebecca Parlakian as a joint production of Child Care Aware and ZERO TO THREE, this brochure offers some guidelines on how to use what parents know about their infant or toddler – like personal style and activity level – to select a child care setting that's just right. The questions presented stimulate parents to develop a profile of their child and learn more about the type of care that might best meet their child's needs. Includes information on health and safety, sleep, cultural identity, and special needs, as well.

Sold in packets of 100 to share in parent education programs, pediatric and health offices, child care centers, resource and referral agencies, and other places where parents gather.

Publication #260, Packet of 100 brochures, \$30.00. For Spanish copies, ask for Publication #261. Single copies available on the Web at www.zerotothree.org

October/November, 2001 – Babies, Toddlers and the Media: What do we know about very young children's media access and media use, and the impact of new media on development? Amy Jordan, Senior Research Investigator, The Annenberg Public Policy Center, will co-edit and contribute to *Zero to Three's* exploration of this question, along with Daniel Anderson and Marie Evans, Susan Linn and Alvin Poussaint, Kyle Pruett, Kelly Schmitt, and Mary Wilds.

December 2001/January 2002 – The Importance of Family and Caregiving Routines: In this issue, Lorraine Kubicek (University of Colorado Health Sciences Center), Guest Editor, and other contributors will examine the links among everyday routines, the quality of infant/caregiver

relationships, and children's competence. They will look at cultural variations, the impact of parental psychopathology, how families adapt routines for young children with disabilities, routines as a way of regulating behavior and promoting feelings of belonging in child care settings, and strategies for helping families maintain competence through meaningful rituals.

February/March 2002 – Agents of Change for Infants and Toddlers in Foster Care: This issue will focus on how individuals and groups, in different roles and circumstances, are making thoughtful efforts to improve outcomes for individual children and to change systems, with promising results.

THE EDITORIAL MISSION OF THE ZERO TO THREE BULLETIN

To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler and family field.

THE MISSION OF ZERO TO THREE: NATIONAL CENTER FOR INFANTS, TODDLERS AND FAMILIES

ZERO TO THREE is a national nonprofit whose mission is to promote the healthy social, emotional and intellectual development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf.

www.zerotothree.org

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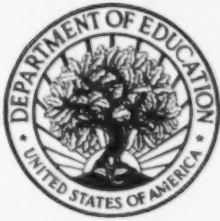


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